
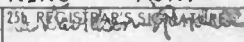


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST LOUIS		MIDDLE HAUCK		LAST GABEL		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2/2 19 85		7. HOUR 7:35 A. M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 26, 1905		6. AGE (IN YEARS) LAST BIRTHDAY 79 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2/2 19 85		7. HOUR 7:35 A. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13523 Vandalia Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DIRECTOR VA BENEFITS		12b. KIND OF BUSINESS OR INDUSTRY VA. ADM.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13523 Vandalia Drive 20853			
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS GABEL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE HAUCK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT MARGARET E. GABEL		ADDRESS SAME AS 13		WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) chronic myocardial disease and emphysema. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy		M.D.		MEDICAL EXAMINER 1919 Seminary Road		DATE SIGNED 2/2/85			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/5/85		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN				23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		500 UNIV. BLVD. W., SILVER SPRING, MD.		25a. DATE REC'D. BY REGISTRAR FEB 7 1985		25b. REGISTRAR'S SIGNATURE 					

BP

John S. Rogers, M.D.

Silver Spring, Montgomery, Md.
1919 Seminary Road
Deputy

X

X

None

None

None

chronic myocardial disease and emphysema.
acute myocardial disease

Maryland Montgomery Rockville
15523 Vandalia Drive
Rockville 15523 Vandalia Drive
Montgomery County

Male White Nov. 26, 1905 75

X

10012 H. GABRIEL

5/5

65 A. 7:55

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LOREN H. GAIR						2a. DATE OF DEATH MONTH 2 / DAY 23 / YEAR 1985				2b. HOUR 6:00 P. M.	
1. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DEC / DAY 5 / YEAR 1917		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS / DAYS 		7b. IF UNDER 24 HRS. HOURS / MIN. 	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH TOKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FED GOVT N.R. TD (CET)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY PR. GEO		13c. CITY OR TOWN TOKOMA PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 608 ELM AVENUE 20912			
14. FATHER'S NAME FIRST HENRY MIDDLE LAST GAIR				15. MOTHER'S MAIDEN NAME FIRST EVELYN MIDDLE LAST MARTIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. N.H.-T 578-18-6009		17. INFORMANT ADDRESS MIRIAM E GAIR - 608 ELM AVE T.P. MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the Stomach with Metastases DUE TO, OR AS A CONSEQUENCE OF (b) to the Lungs, Liver, and Cervical Spine DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) ① Mild Congestive Heart Failure ② Pulmonary Effusion ③ Pulmonary Embolism											
19a. DATE OF OPERATION 12/25/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Severe Gastric Bleeding				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2/23/85 to 2/23/85 , that (I) (we) lost saw the deceased alive on 2/23/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Alan R. Gair				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/23/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan R. Gair MD				22e. ADDRESS 11700 Old Columbia Pike Silver Spring, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried		23b. DATE Feb. 27 1985		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery				23d. LOCATION CITY OR TOWN Cheltenham COUNTY MD			
24. FUNERAL DIRECTOR NAME Takoma Funeral Home J.C. Walker ADDRESS 2500 Carroll Island Pk				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE FEB 28 1985			

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 5 8 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PRESTON B. GAITHER			2a. DATE OF DEATH MONTH DAY YEAR February 17, 1985		2b. HOUR 1:30 am
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR April 1, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cement Finisher		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Damascus	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 27612 Ridge Rd/ 20872	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas E. Gaither		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Atsie N. Welsh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-05-6852	17. INFORMANT ADDRESS Julia A. Gaither, Item 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Small Cell Carcinoma R Lung*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 yr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Metastasis to lymph nodes, lungs, bone marrow; Gallstones. Pancytopenia.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <i>May</i> , 19 <i>84</i> , to <i>17 Feb</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>16 Feb</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did not)</i> view the body after death.			
22b. SIGNATURE <i>Donald E. Dillon M.D.</i>		DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>17 Feb 85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Donald E. Dillon, M.D.</i>		22e. ADDRESS <i>2901 Olney-Sandy Spring Rd Olney Md 20832</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 20, 1985	23c. NAME OF CEMETERY OR CREMATORY Friendship Meth.	23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montgomery, Md.
24. FUNERAL DIRECTOR Orin L. Molesworth, P.A., ADD Damascus, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>FEB 25 1985 Julia A. Gaither</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1:30 pm	February 17, 1982	W. J.
	
	
	
	
	
	
	
	
	

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified by the coroner.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR am M			
1. DECEASED NAME (TYPE OR PRINT)		7a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR am M			
Vassiliki Galanis		February 6, 1985				11:09 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Caucasian		April 21, 1896		88			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Greece		Greece				Montgomery County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital				Homemaker		Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland		Montgomery		Potomac		13e. STREET ADDRESS / ZIP CODE			
						8802 Tuckerman Lane 20854			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		ADDRESS					
Gus Tzanetos		Maria Asimakis		8802 Tuckerman Lane					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Son)		ADDRESS			
No		N/A		John Galanis		8802 Tuckerman Lane, Potomac, Maryland 20854			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) Septic Shock									
DUE TO, OR AS A CONSEQUENCE OF (c) Urinary Tract Infection									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic Heart Disease, Respiratory Insufficiency									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) (this hospital) attended the deceased from 2/5 1985, to 2/6/ 1985, that (i) (we) last saw the deceased alive on 2/5/ 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
Peter Sherer MD						2/6/1985			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Peter B. Sherer, M.D.		3947 Ferrara Drive, Wheaton, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		February 9,		Parklawn Memorial Park		Rockville Montgomery Maryland			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Avenue, Bethesda, Maryland		FEB 14 1985		Jana Davidson					

20

20% COTTON FIBER

WHEATON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) VERA FITCHETT GARDNER				2a. DATE OF DEATH FEBRUARY 14, 1985		2b. HOUR 12:50 P M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH JULY 26, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13e. STREET ADDRESS / ZIP CODE 261 CONGRESSIONAL LANE 20852	
14. FATHER'S NAME ROY REID FITCHETT				15. MOTHER'S MAIDEN NAME GRACE HALE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 230-18-7153		17. INFORMANT ADDRESS HEBER CASSELL GARDNER, JR. 261 CONGRESSIONAL LANE #417, ROCKVILLE, MD 20852			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) emphysema DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 7, 1984 , to FEBRUARY 14, 1985 , that (I) (we) lost saw the deceased alive on FEBRUARY 14, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the death after death.							
22b. SIGNATURE <i>W. A. Delacey</i>				DEGREE MD		22c. DATE SIGNED 15 Feb 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. A. DELACEY, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/18/1985		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc				ADDRESS 5130 Wisc. Ave. Washington, D.C.		25a. DATE REC'D. BY REGISTRAR FEB 22 1985	
				25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

BP _____

CHIEF IN CHARGE

20% COTTON 20%

General (and) John, Inc.
2/18/55

Washington, D.C.
John, Inc.
2/18/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may file minutes at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
			ROBERT GRUDZINSKI GARIN		FEBRUARY 13 1985	
3. SEX			4. RACE		5. DATE OF BIRTH	
MALE			CAUCASIAN		JULY 21 1914	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. AGE (IN YEARS LAST BIRTHDAY)	
GERMANY			UNITED STATES		70 YRS.	
9. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BETHESDA			NAVAL HOSPITAL		MANAGER	
13a. STATE			13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE	
MARYLAND			PRINCE GEORGE'S GREENBELT		29 LAKESIDE DRIVE 20770	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		12b. KIND OF BUSINESS OR INDUSTRY	
BARUCH GRUDZINSKI			EVA ZIPERKOWSKI		INSURANCE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO			119-24-5113		SONIA G. GARIN, 29 LAKESIDE DRIVE, GREENBELT, MD 20770	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANGIOIMMUNOBLASTIC LYMPHADENOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 5</u> , 19 <u>85</u> , to <u>FEBRUARY 13</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>FEBRUARY 13</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE 			DEGREE MD			22c. DATE SIGNED
H. P. LIEBERT, LT, MC, USNR			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			14 FEB 1985
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			
			NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (RECEIPT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		2/15/85		King David Mem. Garden		Falls Church; Fairfax, Va.
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DANZANSKY-GOLDBERG MEMORIAL CHAPELS			FEB 1 9 1985			
1170 Rockville Pike; Rockville, Md. 20852						



2025 COLLECTION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR											
2a DECEASED NAME (TYPE OR PRINT)					2b DATE OF DEATH					2c HOUR	
Anita F. Garlem					February 25, 1985					12:00AM	
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
Female		Caucasian		April 7, 1900			84 YRS			MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		United States						Montgomery County, MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Kensington		Kensington Gardens Nursing Center					Salesperson			Retail	
13a STATE			13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Maryland			Montgomery		Rockville		13e. STREET ADDRESS / ZIP CODE 20852				
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					
Burl Brady Malone			Nettie Belle Mosier			16b. SOCIAL SECURITY NO. 214-05-8067					
17 INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								
			IMMEDIATE CAUSE (a) <u>pneumonia</u>								
			DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic organic brain syndrome</u>								
			DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>								
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>Apr 8</u> , 19 <u>84</u> , to <u>Feb 25</u> , 19 <u>85</u> , that (2) (we) lost the deceased alive on <u>Feb 22</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE			22c. DEGREE			22d. DATE SIGNED			22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
Robert J. Lindeman MD						Feb 25/85					
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ADDRESS			22h. DATE REC'D. BY REGISTRAR					
R. J. LINDEMAN M.D.			10215 FERNWOOD RD, Bethesda MD 20817			FEB 28 1985					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			Feb. 27, 1985			Rock Creek Cemetery			Washington, D.C.		
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			24c. DATE REC'D. BY REGISTRAR			24d. REGISTRAR'S SIGNATURE		
Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland						FEB 28 1985			R. Lindeman		

12

20% COTTON FIBER

100% COTTON FIBER



10/21/82

X

10/21/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M
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DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Clark Gibbons										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2 4 19 85	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 23 1935	6. AGE (IN YEARS) (LAST BIRTHDAY) 49 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 4 19 85		2d. HOUR 6 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 348 Rutgers Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer operator		12b. KIND OF BUSINESS OR INDUSTRY N.A.S.A.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 348 Rutgers Street 20850			
14. FATHER'S NAME FIRST MIDDLE LAST William Gibbons				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Battley				ADDRESS 12804 Evanston St., Helen Gibbons-Mother-Rockville, Md. 20852			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Helen Gibbons-Mother-Rockville, Md. 20852							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Diabetes mellitus</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> (Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 2/5/85			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St.				Balto., MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 8, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Georges Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				ADDRESS 11800 N.H. Ave., Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR FEB 7 1985		25b. REGISTRAR'S SIGNATURE	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ADOLPHUS THEOPHILUS GIBSON		2a. DATE OF DEATH MONTH DAY YEAR Feb 4 '85		2b. HOUR PM 7:16 M
3. SEX Male	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR March 5 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Guyana	7b. CITIZEN OF WHAT COUNTRY? U.S. AGuyana	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter/Construction	
13a. STATE MD.	13b. COUNTY Montgomery	13c. CITY OR TOWN Takoma Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edmond Gibson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Thomas		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 120-48-5513		17. INFORMANT ADDRESS Mildred Marcus Gibson (wife) Ulric P. Gibson (son) Silver Spring, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 7 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Disinfect				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2/1/85 to 2/4/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Thos G. Ward		DEGREE MD		22c. DATE SIGNED 2/5/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward		22e. ADDRESS 6116 Rockwood, Bethesda 20817		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02/07/85	23c. NAME OF CEMETERY OR CREMATORY Washington National Suitland, P.G. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS LATNEY's Funeral Home 3831 Georgia Ave. NW, Washington, DC 2001		25a. DATE REC'D. BY REGISTRAR FEB 13 1985		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "not at work," then any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

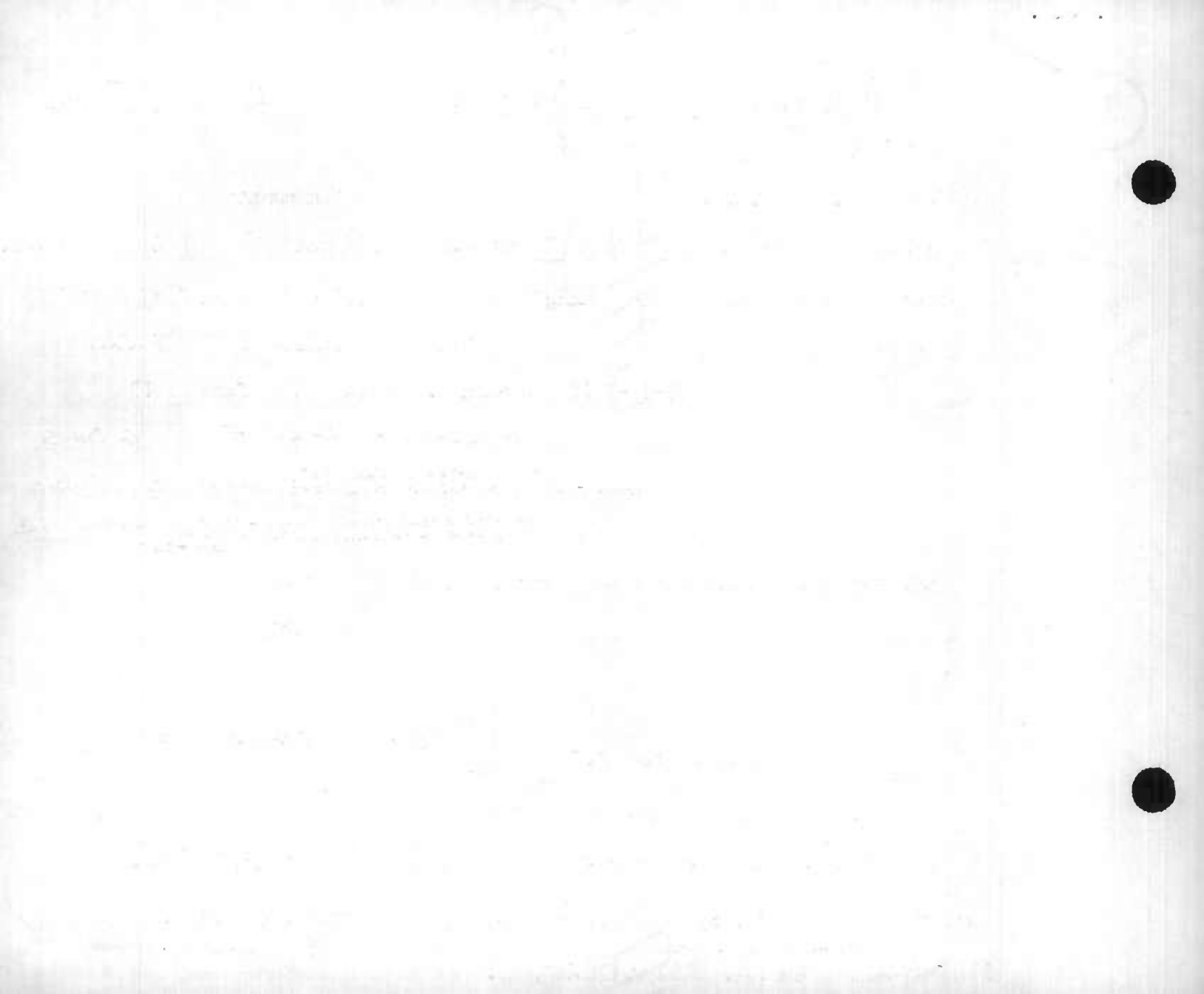
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
William P. Gibson		2 21 85		2244 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	White	8 MONTH 1 DAY 11 YEAR	73 YRS	Montgomery MD.	
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D. C.	U.S.A.		Montgomery		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park	Washington Adventist Hospital	Shipper	Giant Food, Inc.		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Montgomery	Silver Spring	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	8712 Colesville Road # 404 20910	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
Fielder	Mary Elizabeth Tarlton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS			
No	577-10-8912	Louise B. Gibson Wife Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (b) MULTICYSTIC FAILURE HEART, LUNGS, KIDNEYS, LIVER, BRAIN					FEW MONTHS
DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE - ARTERIOSCLEROTIC HEART DISEASE					SEVERAL YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
LEFT CEREBROVASCULAR OCCLUSION					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 60 to February 19 85, that (I) (we) lost, saw the deceased alive on February 20 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Robert L. Krichmar	MD			February 21 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
ROBERT L. KRICHMAR	7733 ALASKA AVENUE N.W. WASHINGTON D.C. 20012				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	Feb. 25, 1985	Parklawn Cemetery	Rockville Montgomery Maryland		
24. FUNERAL DIRECTOR NAME	24b. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE		
Francis J. Collins	FEB 25 1985		[Signature]		
500 University Blvd., W. Silver Spring, Md.					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR	
Peter		A.		Giroux				2-20		19 85		10:16 p. M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD		8. MONTH DAY YEAR		9. HOUR	
Male	Caucasian	Sept. 29, 1959		25 YRS.				2-20		19 85		10:16 p. M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Washington, D.C.		USA				Montgomery County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda		Suburban Hospital		Clerk - Driver		Pharmacy							
13a. STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Montgomery		Kensington				11414 Soward Drive		21834			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Francis		A.		Giroux		Helen		Valentine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		228-94-2254		Helen V. Giroux		7216 Commerce St. T-4 Springfield, Va. 22150							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt Trauma to Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:30xx 2-16 19 85				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was assaulted					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Grandview Ave. & Reedie Dr., Wheaton, Mont- gomery Co., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) D. Assistant MEDICAL EXAMINER				DATE SIGNED 2-21-85					
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL Cremation				23b. DATE Feb. 23, 1985				23c. NAME OF CEMETERY OR CREMATORY Lee Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR Murphy Funeral Home				ADDRESS Arlington, Va. 22203				25a. DATE REC'D. BY REGISTRAR FEB 27 1985				25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

РАЙОН МОЛТОС 2002

ОДНО
МЕСТНО
ЖИЗ



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 5 9 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert Edward Godfrey			2a. DATE OF DEATH MONTH DAY YEAR 2 20 1985			2b. HOUR 9:42 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 28 23		6. AGE (IN YEARS LAST BIRTHDAY) 61 yrs. YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Customer Service		12b. KIND OF BUSINESS OR INDUSTRY C & P			
13a. STATE Maryland			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8209 18th Avenue 20783		
14. FATHER'S NAME FIRST MIDDLE LAST Raymond Berry Godfrey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Mildred McDonald							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 579-16-0540		17. INFORMANT Brother Donald R. Godfrey			ADDRESS 3292 Green Ash Road Davidsonville, Md. 21035			
18. CAUSE OF DEATH (Enter only one cause per line for the terminal disease or condition) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a) <u>Urinary Retention</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>17 Feb</u> 19 <u>85</u> to <u>20 Feb</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>20 Feb</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thomas P. Fogarty, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 21 Feb 85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas P. Fogarty, M.D.			22e. ADDRESS 7676 New Hampshire Ave. Langley Park, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 23, 1985		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.				
24. FUNERAL DIRECTOR NAME Francis J. Collins			ADDRESS 500 University Blvd., W. Silver Spring, Md.			25. DATE REC'D. BY REGISTRAR FEB 25 1985		25b. REGISTRAR'S SIGNATURE K. Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 410-326-7000.

BP

[Faint, illegible handwriting on lined paper]

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GOLDIE (NMN) GOLDMAN						2a. DATE OF DEATH MONTH DAY YEAR February 12, 1985		2b. HOUR 11:09 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 9, 1921		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 63		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. IMPORT AND EXPORT			
13a. STATE New York		13b. COUNTY		13c. CITY OR TOWN Bronx		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2190 Bolton St., 10462			
14. FATHER'S NAME FIRST MIDDLE LAST NATHAN GOLDMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA GOLDMAN KESSLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 093-14-0154		17. INFORMANT ADDRESS Mrs. Ruth Simball (sister) Hyattsville, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Leukemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes days months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Ovarian cancer treated with chemotherapy											
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I <input checked="" type="checkbox"/> this hospital) attended the deceased from AUG. 19, 1981 , to February 12, 1985 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 12, 1985 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE OF PHYSICIAN <i>[Signature]</i>								22c. DATE SIGNED 2/13/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Salwitz								22e. ADDRESS NATIONAL INSTITUTES OF HEALTH BETHESDA, MD. 20905			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 2/15/1985		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY				23d. LOCATION BROOKLYN, NEW YORK			
24a. NAME OF FUNERAL HOME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME								24b. DATE REC'D. BY REGISTRAR FEB 19 1985		24c. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24d. ADDRESS 232 CARROLL STREET, N.W., WASHINGTON, D. C.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried within 72 hours after death. The third copy should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried within 72 hours after death. The third copy should be retained by the funeral director.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 5 9 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jacob			FIRST MIDDLE LAST Goldman			2a. DATE OF DEATH MONTH DAY YEAR 2 16 85			2b. HOUR 8:30 AM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Nov. 8, 1883			6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Wash.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner (Ret)			12b. KIND OF BUSINESS OR INDUSTRY Grocery Store		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Rockville			13e. STREET ADDRESS / ZIP CODE 6121 Montrose Road 20852		
14. FATHER'S NAME FIRST MIDDLE LAST Moshe Mordecai Goldman						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shiffra Fradel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-48-0915			17. INFORMANT Bethesda, Md. 20817 Dorothy Zendel; 7420 Westlake Terr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) flu-like illness DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: senile dementia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 29, 1985 to Feb 16, 1985 , that (I) (we) last saw the deceased alive on 1/22/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Mark Rosen			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/16/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Rosen			22e. ADDRESS Silver Spring, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-18-1985			23c. NAME OF CEMETERY OR CREMATORY Beth Shalom Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Capitol Hts., Md.		
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike						25a. DATE REC'D. BY REGISTRAR FEB 21 1985					
25b. REGISTRAR'S SIGNATURE John Anderson-Rendell											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a certain time after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		7a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		7b. HOUR		MIN			
Annz		C		Goodman				Feb. 11		19		58				P		M			
1. SEX	2. RACE	3. DATE OF BIRTH		4. AGE (IN YEARS)		5. IF UNDER 1 YR.		6. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. HOUR		MIN	
F	W	Aug 2 04		80		YRS.				Feb. 11		19		58				P		M	
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7f. CITY OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH													
Brooklyn, NY		USA		WIDOWED		DIVORCED		Montgomery, MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
St. Louis		Holy Cross Hosp		Secretary		Schools															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MD		Montgomery		St. Louis		YES		1404 16th St													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Aaron		Ethel		216 46 2939		Robert Goodman		10400 Great Arbor Dr.,													
18a. WAS DECEASED EVER IN U.S. ARMED FORCES?		18b. SOCIAL SECURITY NO.		18c. CITY OR TOWN		18d. INSIDE CITY LIMITS?		18e. STREET ADDRESS													
No		N/A		216 46 2939		YES		1404 16th St													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
				Acute myocardial infarction																	
				(b)		DUE TO, OR AS A CONSEQUENCE OF															
				(c)		DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO													
1-21-85		Spine stenosis		YES		NO															
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. PLACE OF INJURY		21e. LOCATION													
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		(AT HOME, STREET, FACTORY, FARM, ETC.)		CITY OR TOWN		COUNTY		STATE									
21f. INJURY OCCURRED		21g. PLACE OF INJURY		21h. LOCATION																	
WHILE AT WORK		STREET, FACTORY, FARM, ETC.)		CITY OR TOWN																	
22a. I certify that I took charge of the remains described above, held an		Autopsy		Inspection		Inquiry		and in my opinion													
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner											
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED															
John S. Rogers, M.D.		M.D.				Feb 12 1985															
EXAMINER'S NAME		ADDRESS		23a. NAME OF CEMETERY OR CREMATORY		23b. LOCATION		COUNTY		STATE											
(TYPE OR PRINT)				DC Hebrew Beneficial Association		Washington, D.C.															
24. FUNERAL DIRECTOR		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION		COUNTY		STATE											
NAME		Feb. 13, 1985		DC Hebrew Beneficial Association		Washington, D.C.															
Ives-Pearson Funeral Homes, FC, Va. 22046																					

FEB 20 1985

Handwritten notes and a circular stamp on lined paper.

Handwritten text (faint, mostly illegible):

- Top section: Several lines of cursive handwriting.
- Middle section: A large, faint, circular stamp or watermark, possibly containing the word "LIBRARY" or similar.
- Bottom section: More handwritten notes, including a date that appears to be "1915".

Circular stamp (bottom right):

- Contains the word "LIBRARY" in a circular arrangement.
- Inside the circle, there is a date: "1915".

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 5 9 5

1- FOR
STATE
REGISTRAR

REG. NO.

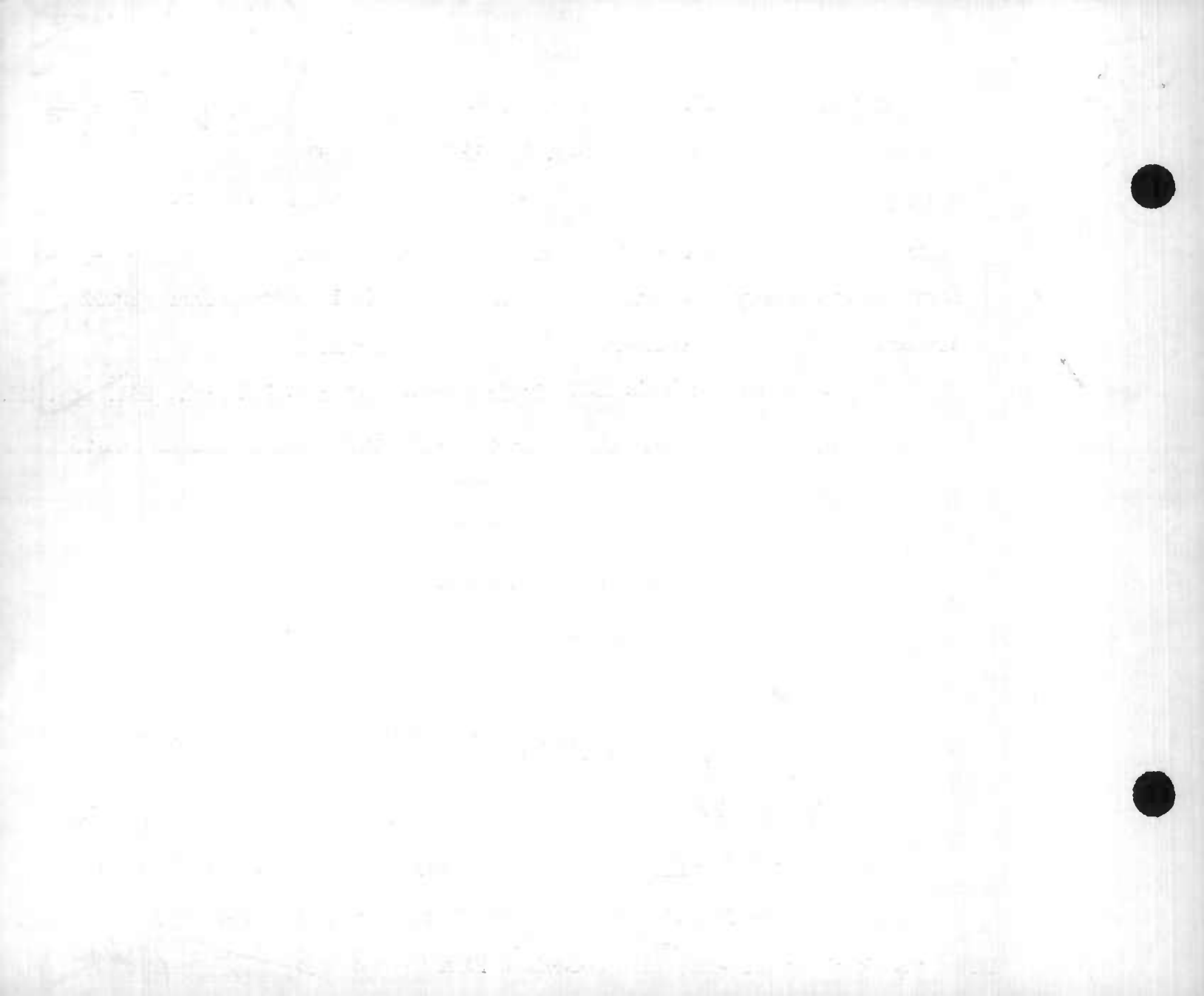
1. DECEASED NAME (TYPE OR PRINT) FRANCES E. GORDON			2a. DATE OF DEATH MONTH 2 DAY 9 YEAR 85			2b. HOUR 5:49 A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Dec. DAY 13 YEAR 1893		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland COUNTY Montgomery					13b. CITY OR TOWN Rockville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 6121 Montrose Road 20852	
14. FATHER'S NAME FIRST Isadore MIDDLE Goldman LAST Goldman					15. MOTHER'S MAIDEN NAME FIRST (Unknown) MIDDLE (Unknown) LAST (Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 565-18-5507		17. INFORMANT ADDRESS 20906 Tavia Gordon; 12901 Bluhill Rd., Sil. Spg., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PERITONITIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS		
DUE TO, OR AS A CONSEQUENCE OF (b) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): CARCINOMA OF COLON										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/6/81 to 2/9/85 , that (I) (we) last saw the deceased alive on 2/9/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE D.J. Patel					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-9-1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.J. PATEL					22e. ADDRESS 6121 MONTROSE RD ROCKVILLE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-12-1985		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens		23d. LOCATION CITY OR TOWN Olney COUNTY Maryland STATE			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike					25a. DATE REC'D. BY REGISTRAR FEB 13 1985 25b. REGISTRAR'S SIGNATURE Johanna Davidson-Rindel					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 should only injury, or other traumatic event, the medical examiner will be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARY OLIVIA GREEN			2a. DATE OF DEATH Month FEBRUARY Day 4 Year 1985		2b. HOUR 6 P.M.
3. SEX Female	4. RACE American White	5. DATE OF BIRTH 2/17/1900		6. AGE (In years last birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SCHOOL TEACHER	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN POOLESVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 19960 FISHER AVE	
14. FATHER'S NAME ROBERT JONES GREEN	15. MOTHER'S MAIDEN NAME LAURA CRAWFORD	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			
16b. SOCIAL SECURITY NO. 219-36-7828	17. INFORMANT CHARLES ELGIN		Address 17909 ELGIN RD, POOLESVILLE, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Idiopathic pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Senile Dementia					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 9, 1950 , to Feb 4, 1985 , that (I) (we) lost the deceased alive on Feb 4, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John J. Fawcett	DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2/4/85
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 2/7/85	23c. NAME OF CEMETERY OR CREMATORY FOREST OAK	23d. LOCATION (City or Town) (County) (State) GAITHERSBURG MONTG. MD.		
24. FUNERAL DIRECTOR W. C. Barnett	ADDRESS Barnesville Md.	25a. REC'D BY REGISTRAR FEB 13 1985	25b. REGISTRAR'S SIGNATURE John Davidson		

RECEIVED
DEPARTMENT OF HEALTH AND HUMAN SERVICES
FEBRUARY 1963



831 81 831

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	A	M
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		FEBRUARY 25, 1985		8:50	
JOSEPH (NMN) GREENSTEIN									
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE	WHITE	MONTH DAY YEAR DEC 15, 1920		64		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
CONNECTICUT	USA			MONTGOMERY COUNTY				MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
BETHESDA	THE CLINICAL CENTER, NIH		Teacher (Ret)		Technical School				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
CONNECTICUT		W. HARTFORD	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	253 BALLARD DRIVE		06119			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST MAX GREENSTEIN		FIRST MIDDLE LAST CLARA (unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
NO		048-01-5184		RUTHE D. GREENSTEIN (WIFE)		SAME AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANAPHYLAXIS TO HORSE SERUM								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY ARREST								60 minutes	
DUE TO, OR AS A CONSEQUENCE OF (c) LARYNGEAL EDEMA								60 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a APLASTIC ANEMIA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 20, 1985, to February 25, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 25, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did) (did not) sign the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
W.J. Gray		NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		2-27-1985		ADATH ISRAEL CEMETERY		FAIRFIELD, CONNECTICUT			
24. FUNERAL DIRECTOR NAME		Rockville, Maryland		25. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Danzansky-Goldberg Chapels; 1170 Rockville Pike				FEB 28 1985		John Davidson			

7

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 5 9 8

10-5-85

FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
George E Greenway

2a. DATE OF DEATH MONTH DAY YEAR
2/21/85

2b. HOUR
7:35 A M

3. SEX
male

4. RACE
white

5. DATE OF BIRTH MONTH DAY YEAR
11 17 06

6. AGE (IN YEARS LAST BIRTHDAY) YRS
78

IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Indiana

7b. CITIZEN OF WHAT COUNTRY?
United States

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD

10. CITY OR TOWN OF DEATH
Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Potomac Valley Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Editor

12b. KIND OF BUSINESS OR INDUSTRY
U.S. Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland

13b. COUNTY
Montgomery

13c. CITY OR TOWN
Chevy Chase

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS
20815 4412 Stanford Street

14. FATHER'S NAME FIRST MIDDLE LAST
James L. Greenway

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary B. Turpin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW II

16b. SOCIAL SECURITY NO.
220-44-5912

17. INFORMANT ADDRESS
Constance S. Greenway, same as #13

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Coronary heart disease**
DUE TO, OR AS A CONSEQUENCE OF (b) **generalized arteriosclerosis**
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year
5 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
① Emphysema ② Carcinoma of prostate

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **Jan 2, 1985** to **Feb 21, 1985**, that (I) (we) saw the deceased alive on **Feb 20, 1985**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

22b. SIGNATURE DEGREE
Dr. Joseph Kenrick M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED
2/21/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR JOSEPH KENRICK

22e. ADDRESS
6450 Wisconsin Ave, Bethesda, Md 20815

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
Feb. 23, 1985

23c. NAME OF CEMETERY OR CREMATORY
Parklawn Mem. Park

23d. LOCATION CITY OR TOWN COUNTY STATE
Rockville, Maryland

24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814

25a. DATE REC'D. BY REGISTRAR
FEB 25 1985

25b. REGISTRAR'S SIGNATURE
G. Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shown, any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARY PAULINE GROMMON				2a. DATE OF DEATH MONTH DAY YEAR February 23, 1985		2b. HOUR 4:55am	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 6, 1904		6 AGE (IN YEARS (LAST BIRTHDAY)) 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Factory Worker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Irvin Shephard		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Mae Morton		13e. STREET ADDRESS / ZIP CODE 12703 Valleywood Drive 20906			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 480-18-7417		17 INFORMANT ADDRESS Sharon Laurienzo same as 13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic breast cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH June 1979	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/13 19 85 , to 2/23 19 85 , that (I) (we) last saw the deceased alive on 2/23 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did not view the body after death.							
22b. SIGNATURE John G. Lodmell		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/23/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. LODMELL MD		22e. ADDRESS 2901 OLNEY-SANDY SPRING RD, OLNEY MD 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/25/85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION Brentwood, Maryland STATE	
24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

MAR 1 1985

February 23, 1952

CHICAGO

CHICAGO

Montgomery

Montgomery General Hospital

Olney

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5152

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR P M	
1. DECEASED NAME (TYPE OR PRINT) FIRST Edward G. LAST Haddad, Sr. EDWARD G. HADDAD						2a. DATE OF DEATH MONTH DAY YEAR 2 23 85						2b. HOUR 5 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 30 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Retir. & Nursing Center						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Officer (Ret)		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>						13b. STREET ADDRESS / ZIP CODE 4620 N. Park Ave. 20815	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		14. FATHER'S NAME FIRST Middle LAST George Marcel Haddad						15. MOTHER'S MAIDEN NAME FIRST Middle LAST Emilie LaSoer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW11		17. INFORMANT ADDRESS Silver Spring, Md. 10226 Capitol View Ave.,		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal failure DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years - 6 months	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 11/16, 1984, to 2/23, 1985, that (I) (we) last saw the deceased alive on 2/15, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE John G. Fawcett, M.D.				DEGREE				22c. DATE SIGNED 2/23/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John G. Fawcett, M.D.				22e. ADDRESS 16610 Sugar Land Rd., Boyds, Md. 20841									
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 2/26/1985		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia							
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave., N.W. Wash., D.C.						25a. DATE REC'D. BY REGISTRAR FEB 28 1985						25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

7

DATE
TIME
X

silver spring

Montgomery

George	Marcel	Haddad	Emilie	Lasoor
Yes	WMI	225-05-0763	Audrienne Jacobs. 10226 Capitol View Ave., Silver Spring, Md.	

John D. Moore, R.D.
2/6/1965
John D. Moore, R.D.
2/6/1965
John D. Moore, R.D.
2/6/1965

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>FLOYD Odell HAEFNER</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2/20/85</i>			2b. HOUR <i>8:40</i> M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR <i>5 7 1919</i>		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Carrier	
13a. STATE Maryland		13b. CITY OR TOWN P.G.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 5813 67th Avenue 20737	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Haefner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Leona Noll			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes - Marines W.W.II				16b. SOCIAL SECURITY NO. 483-05-8634		17. INFORMANT ADDRESS Carol F. Haefner (Wife) 1517 12th Street N.W. Wash. D.C. 20005	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Intraventricular hemorrhage*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) *Possible Hypertension*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

*Respiratory failure**Possible Sepsis*

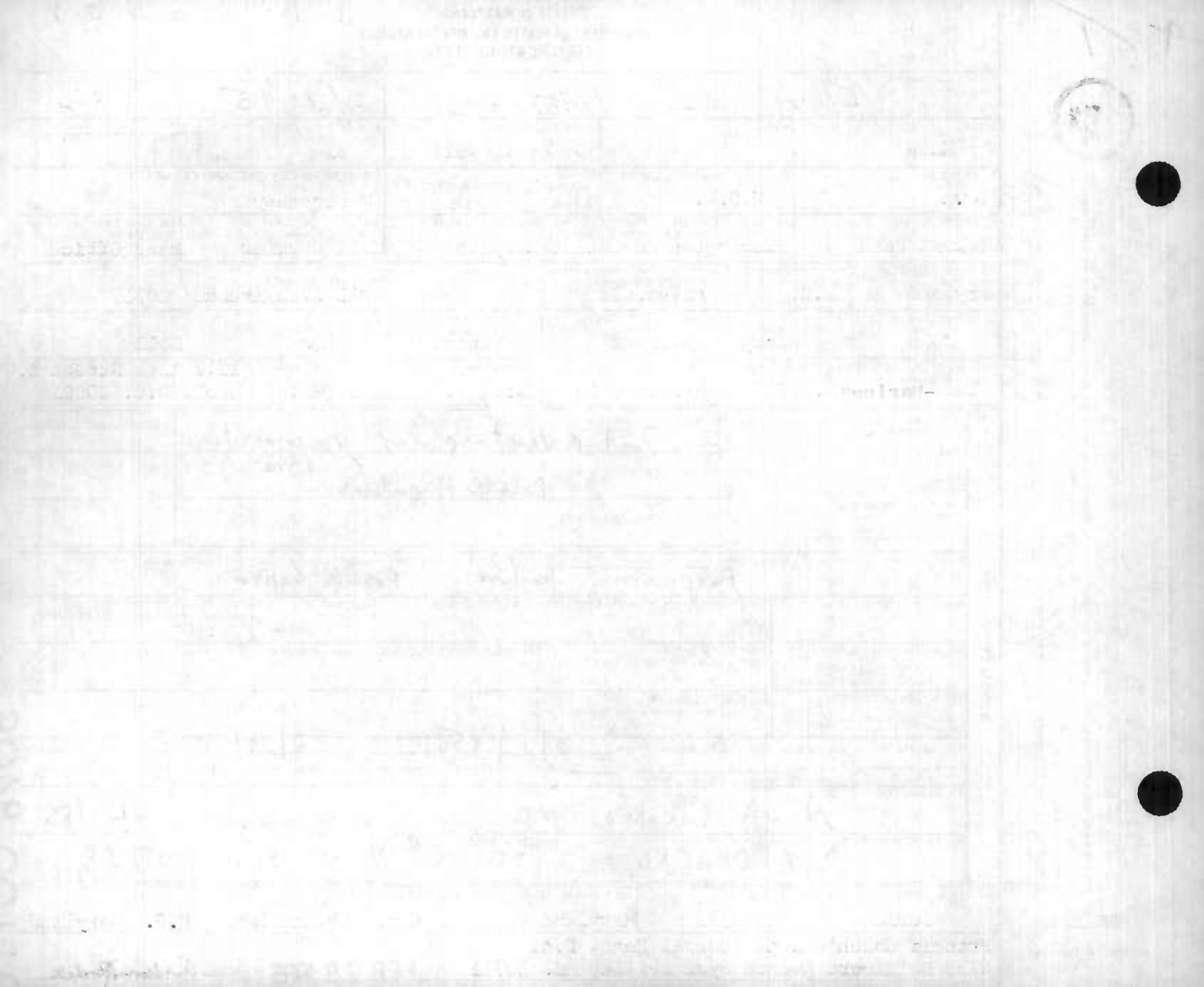
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/11/85</i> 19, to <i>2/17/85</i> 19, that (I) (we) lost saw the deceased alive on <i>2/11/85</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>A. A. Chacko</i>				DEGREE MD		22c. DATE SIGNED <i>2/20/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. A. CHACKO</i>				22e. ADDRESS <i>8500, 16th St. G3, Silver Spring MD 20910</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/25/85		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland	
24. FUNERAL HOME OR NAME Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR FEB 28 1985		25b. REGISTRAR'S SIGNATURE <i>Gutha Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE OF DEATH		2d. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		P M	
Louise M. Hamilton		Feb. 16 19 85		2:15 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Female	White	MARCH 21, 1920	64 YRS.	MONTHS DAYS	HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
ARIZONA	U.S.A.			MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING	3532 PEAR TREE COURT			U.S. GOVT.	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND		MONTGOMERY	SILVER SPRING	XXX NO <input type="checkbox"/>	3532 PEAR TREE COURT 20906
14. FATHER'S NAME (FIRST MIDDLE LAST)			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		
ADOLPH GEORGE McCLOSKEY			ANNA RULE FIFE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
NO		526-20-8434	SON ROBERT HAMILTON, SILVER SPRING, MD. 20904		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Acute Chronic Alcoholism</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:					
(b) _____					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION		
			STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Richard L. Whelton		MD Deputy Medical Examiner		2-76-85	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
RICHARD L. WHELTON		7100 Baltimore Ave College Park			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN)	COUNTY	STATE
BURIAL	2/20/85	GATE OF HEAVEN	SILVER SPRING	MONT	MD.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
FRANCIS J. COLLINS		FEB 26 1985		Richard L. Whelton	
500 UNITV. BLVD., W., SILVER SPRING, MD. 20901					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Eleanor M. Hammer				2a. DATE OF DEATH MONTH DAY YEAR Feb 18 1985			
3. SEX Female				7b. HOUR 5:50 P.M.			
4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4 8 1908		6. AGE (IN YEARS LAST BIRTHDAY) YRS 76		7a. IF UNDER 1 YEAR MONTHS DAYS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House Retir. & Nursing		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exec. Secretary Agriculture		12b. KIND OF BUSINESS OR INDUSTRY Dept. of	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13e. STREET ADDRESS / ZIP CODE 6530 Democracy Blvd, 20817	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Keller Hammer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann May Long			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-22-1968		17. INFORMANT ADDRESS Hazel L. Radier, 6685 Hillandale Rd., Chevy Chase, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Aortic Valvular Heart Disease, Essential Hypertension, Alzheimer's dementia, Depression							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 19 66 to Feb 18 1985 , that (I) (we) last saw the deceased alive on Feb 18 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Robert F. Dyer MD				22c. DATE SIGNED 2-18-85		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. ADDRESS 5530 Wisconsin Ave, Chevy Chase, Md 20815							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/21/1985		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Maryland	
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.				25a. DATE REC'D. BY REGISTRAR FEB 26 1985			
25b. REGISTRAR'S SIGNATURE Julia Furber-Pandell							

X

REF ID: A66004

7-1-58 Daniel J. O'Neil, 685 William St., Chicago, Ill.

• 2011 2010 2009 2008 2007 2006 2005 2004 2003 2002 2001 2000 1999 1998 1997 1996 1995 1994 1993 1992 1991 1990 1989 1988 1987 1986 1985 1984 1983 1982 1981 1980 1979 1978 1977 1976 1975 1974 1973 1972 1971 1970 1969 1968 1967 1966 1965 1964 1963 1962 1961 1960 1959 1958 1957 1956 1955 1954 1953 1952 1951 1950 1949 1948 1947 1946 1945 1944 1943 1942 1941 1940 1939 1938 1937 1936 1935 1934 1933 1932 1931 1930 1929 1928 1927 1926 1925 1924 1923 1922 1921 1920 1919 1918 1917 1916 1915 1914 1913 1912 1911 1910 1909 1908 1907 1906 1905 1904 1903 1902 1901 1900 1899 1898 1897 1896 1895 1894 1893 1892 1891 1890 1889 1888 1887 1886 1885 1884 1883 1882 1881 1880 1879 1878 1877 1876 1875 1874 1873 1872 1871 1870 1869 1868 1867 1866 1865 1864 1863 1862 1861 1860 1859 1858 1857 1856 1855 1854 1853 1852 1851 1850 1849 1848 1847 1846 1845 1844 1843 1842 1841 1840 1839 1838 1837 1836 1835 1834 1833 1832 1831 1830 1829 1828 1827 1826 1825 1824 1823 1822 1821 1820 1819 1818 1817 1816 1815 1814 1813 1812 1811 1810 1809 1808 1807 1806 1805 1804 1803 1802 1801 1800 1799 1798 1797 1796 1795 1794 1793 1792 1791 1790 1789 1788 1787 1786 1785 1784 1783 1782 1781 1780 1779 1778 1777 1776 1775 1774 1773 1772 1771 1770 1769 1768 1767 1766 1765 1764 1763 1762 1761 1760 1759 1758 1757 1756 1755 1754 1753 1752 1751 1750 1749 1748 1747 1746 1745 1744 1743 1742 1741 1740 1739 1738 1737 1736 1735 1734 1733 1732 1731 1730 1729 1728 1727 1726 1725 1724 1723 1722 1721 1720 1719 1718 1717 1716 1715 1714 1713 1712 1711 1710 1709 1708 1707 1706 1705 1704 1703 1702 1701 1700 1699 1698 1697 1696 1695 1694 1693 1692 1691 1690 1689 1688 1687 1686 1685 1684 1683 1682 1681 1680 1679 1678 1677 1676 1675 1674 1673 1672 1671 1670 1669 1668 1667 1666 1665 1664 1663 1662 1661 1660 1659 1658 1657 1656 1655 1654 1653 1652 1651 1650 1649 1648 1647 1646 1645 1644 1643 1642 1641 1640 1639 1638 1637 1636 1635 1634 1633 1632 1631 1630 1629 1628 1627 1626 1625 1624 1623 1622 1621 1620 1619 1618 1617 1616 1615 1614 1613 1612 1611 1610 1609 1608 1607 1606 1605 1604 1603 1602 1601 1600 1599 1598 1597 1596 1595 1594 1593 1592 1591 1590 1589 1588 1587 1586 1585 1584 1583 1582 1581 1580 1579 1578 1577 1576 1575 1574 1573 1572 1571 1570 1569 1568 1567 1566 1565 1564 1563 1562 1561 1560 1559 1558 1557 1556 1555 1554 1553 1552 1551 1550 1549 1548 1547 1546 1545 1544 1543 1542 1541 1540 1539 1538 1537 1536 1535 1534 1533 1532 1531 1530 1529 1528 1527 1526 1525 1524 1523 1522 1521 1520 1519 1518 1517 1516 1515 1514 1513 1512 1511 1510 1509 1508 1507 1506 1505 1504 1503 1502 1501 1500 1499 1498 1497 1496 1495 1494 1493 1492 1491 1490 1489 1488 1487 1486 1485 1484 1483 1482 1481 1480 1479 1478 1477 1476 1475 1474 1473 1472 1471 1470 1469 1468 1467 1466 1465 1464 1463 1462 1461 1460 1459 1458 1457 1456 1455 1454 1453 1452 1451 1450 1449 1448 1447 1446 1445 1444 1443 1442 1441 1440 1439 1438 1437 1436 1435 1434 1433 1432 1431 1430 1429 1428 1427 1426 1425 1424 1423 1422 1421 1420 1419 1418 1417 1416 1415 1414 1413 1412 1411 1410 1409 1408 1407 1406 1405 1404 1403 1402 1401 1400 1399 1398 1397 1396 1395 1394 1393 1392 1391 1390 1389 1388 1387 1386 1385 1384 1383 1382 1381 1380 1379 1378 1377 1376 1375 1374 1373 1372 1371 1370 1369 1368 1367 1366 1365 1364 1363 1362 1361 1360 1359 1358 1357 1356 1355 1354 1353 1352 1351 1350 1349 1348 1347 1346 1345 1344 1343 1342 1341 1340 1339 1338 1337 1336 1335 1334 1333 1332 1331 1330 1329 1328 1327 1326 1325 1324 1323 1322 1321 1320 1319 1318 1317 1316 1315 1314 1313 1312 1311 1310 1309 1308 1307 1306 1305 1304 1303 1302 1301 1300 1299 1298 1297 1296 1295 1294 1293 1292 1291 1290 1289 1288 1287 1286 1285 1284 1283 1282 1281 1280 1279 1278 1277 1276 1275 1274 1273 1272 1271 1270 1269 1268 1267 1266 1265 1264 1263 1262 1261 1260 1259 1258 1257 1256 1255 1254 1253 1252 1251 1250 1249 1248 1247 1246 1245 1244 1243 1242 1241 1240 1239 1238 1237 1236 1235 1234 1233 1232 1231 1230 1229 1228 1227 1226 1225 1224 1223 1222 1221 1220 1219 1218 1217 1216 1215 1214 1213 1212 1211 1210 1209 1208 1207 1206 1205 1204 1203 1202 1201 1200 1199 1198 1197 1196 1195 1194 11

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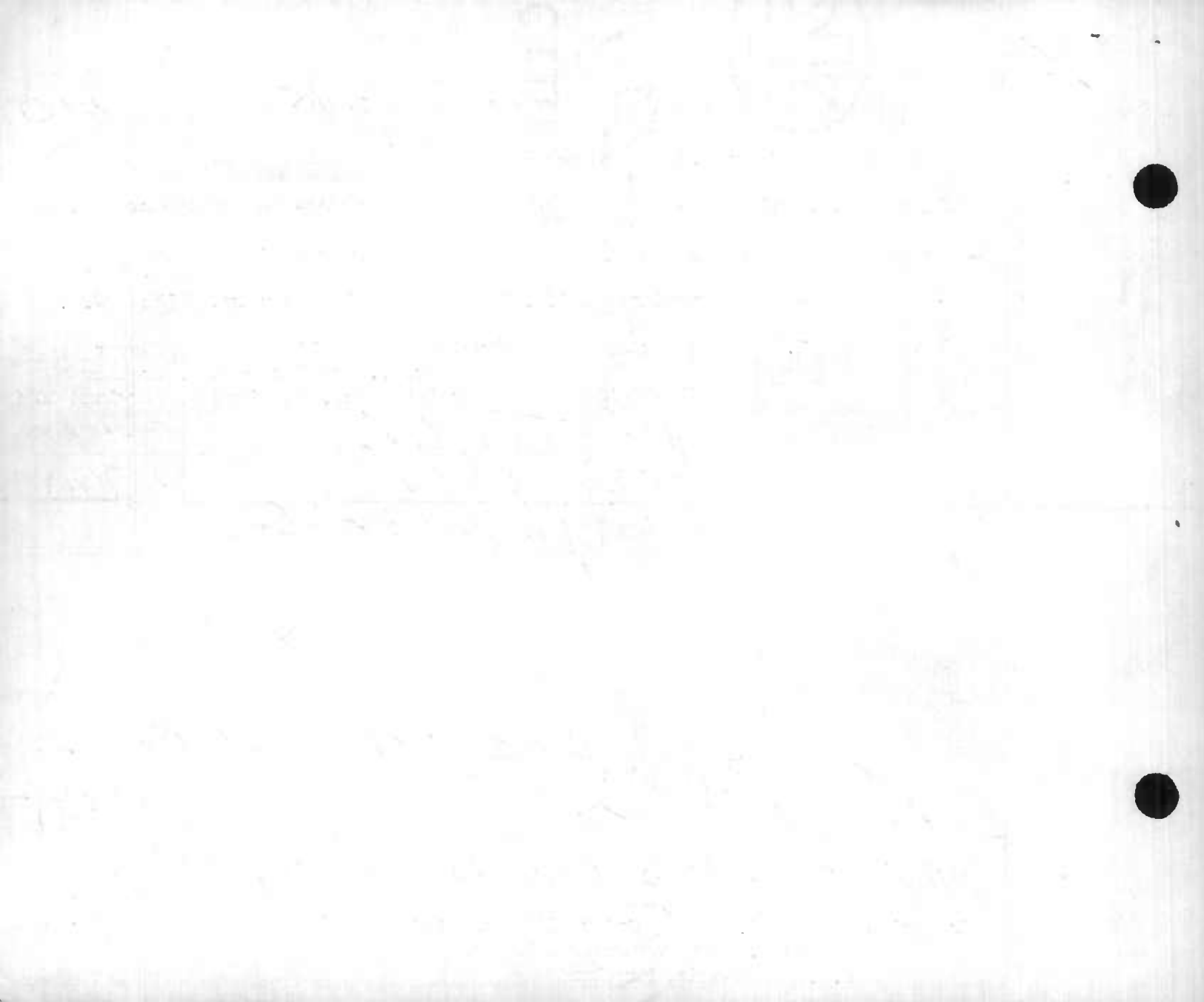
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) Pauline Burton Hancock			2a. DATE OF DEATH MONTH DAY YEAR 2/18/85 1AT			7b. HOUR 10A (M)			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE -		13b. COUNTY -		13c. CITY OR TOWN Washington, D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4201 Butterworth Place, N.W. Zip: 20016-9	
14. FATHER'S NAME FIRST MIDDLE LAST Elmon L. Burton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Elizabeth Hoover					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-36-3368		17. INFORMANT Mr. E. Douglas Burton, Brother 9608 Carriage Road, Kensington, Maryland 20895					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart attack</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>gastro ulcer</u> (c) <u>isopharyngeal varices</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3-4 hrs</u> <u>2 hrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from above (I) (the doctor) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. W. W. W. W.</u>				22c. DEGREE ATTENDING PHYSICIAN				22d. DATE SIGNED 2/18/85	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Ghos B. W. W. W.				22f. ADDRESS 6116 Robinson, Bethesda					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE February 20, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumfrey, Funeral Homes, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR FEB 22 1985		25b. REGISTRAR'S SIGNATURE Davidson-Randall			



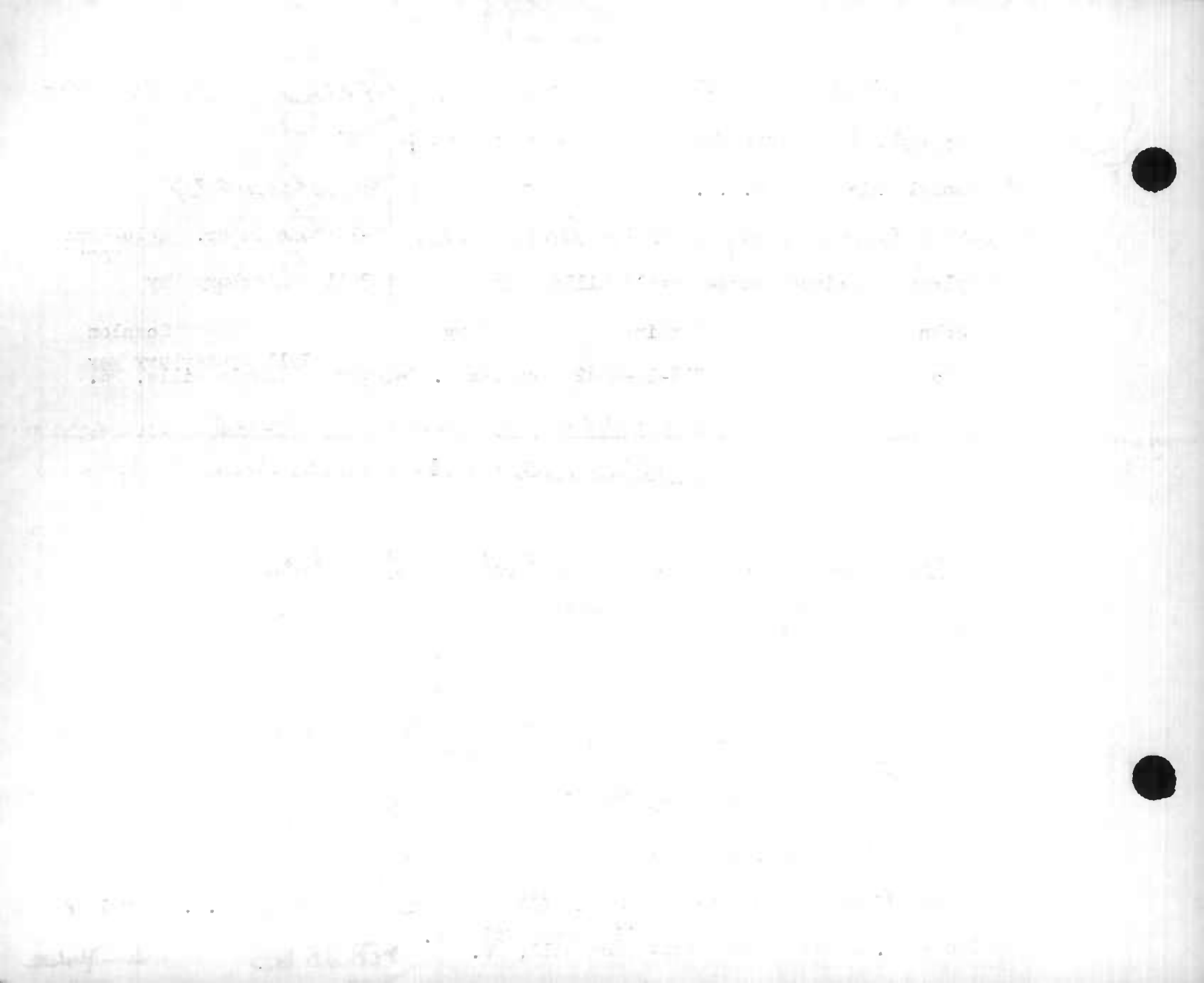
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
SADIE A. HANLAND				Feb.		23 85		8 15 A.M.	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		# UNDER 1 YEAR		# UNDER 24 HRS.	
FEMALE	Caucasian	April 23, 1896		88		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania	U.S.A.			Montgomery				MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring	Holy Cross Hospital		Telephone Super.		Telephone				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE					
Maryland	Prince George	Temple Hills	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3911 Canterbury Way				20748	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
John Harkins		Mary Scanlon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
No		718-14-9882		Ramona H. Solomon					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF							
Cardio pulmonary arrest		(b)		Atherosclerotic Cardio vascular disease				1 year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF							
		(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Cerebral vascular accident, Emphysema									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
AT WORK AT WORK									
22a. I certify that (I) (this hospital) attended the deceased from 6/29 19 78 to 2/23 19 85, that (I) (we) lost saw the deceased alive on 2/23 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
John G. Fawcett				2/24/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JOHN G. FAWCETT		16610 SUGARLAND RD							
		BOYDS, Md 20841							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Cremation		2/25/85		Cedar Hill Crematory		Suitland P.G. Maryland			
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George P. Kalas Funeral Home		6160 Oxon Hill Rd.		Oxon Hill, Md.		FEB 26 1985		S. Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Russell - Hardy SR.			2a. DATE OF DEATH MONTH DAY YEAR 2-10-85		2b. HOUR 3:30 A.M.	
3. SEX Male	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY - 10 - 1893		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			10. CITY OR TOWN OF DEATH Silver Spring			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY LAW	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		
14. FATHER'S NAME FIRST MIDDLE LAST THEODORE - HARDY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY - RUSSELL		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
17. SOCIAL SECURITY NO. 213-46-7883		18. INFORMANT ADDRESS MILDRED HARDY (WIFE) SAME AS #13				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Perforation			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Days		
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Acute Myocardial Infarction					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from January 20, 1985 , to February 10, 1985 , that (I) (we) last saw the deceased alive on February 9, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE Barry Hecht		DEGREE M.D.		22c. DATE SIGNED February 10, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Hecht		22e. ADDRESS 3929 FEDERARA DRIVE WHEATON MD 20906			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE FEB. 10, 1985		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.CO. MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS CHAMBERS FUNERAL HOME SILVER SPRING, MD.			
25a. DATE REC'D. BY REGISTRAR FEB 13 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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MAY 1964
FEB 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause of death.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BESSIE M HARRIS			2a. DATE OF DEATH MONTH DAY YEAR Feb. 16 1985			2b. HOUR 12.30 P.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 28 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Damascus		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 25024 Oak Drive 20872				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 25024 Oak Dr. 20872	
14. FATHER'S NAME FIRST MIDDLE LAST Theodore Gager				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann (Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577 07 2767 B		17. INFORMANT ADDRESS Randall M. Harris Same As 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of colon with DUE TO, OR AS A CONSEQUENCE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized metastases DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/11 , 19 81 , to 2/16 , 19 85 , that (I) (we) last saw the deceased alive on 2/2 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James P. Kerr M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James P. Kerr						22e. ADDRESS Ridge Rd. Damascus Md. 20872			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Feb. 17 1985		23c. NAME OF CEMETERY OR CREMATORY B & W Washington Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Prince George Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Francis H. Barber Laytonsville Md. 20879						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Feb 25 1985	

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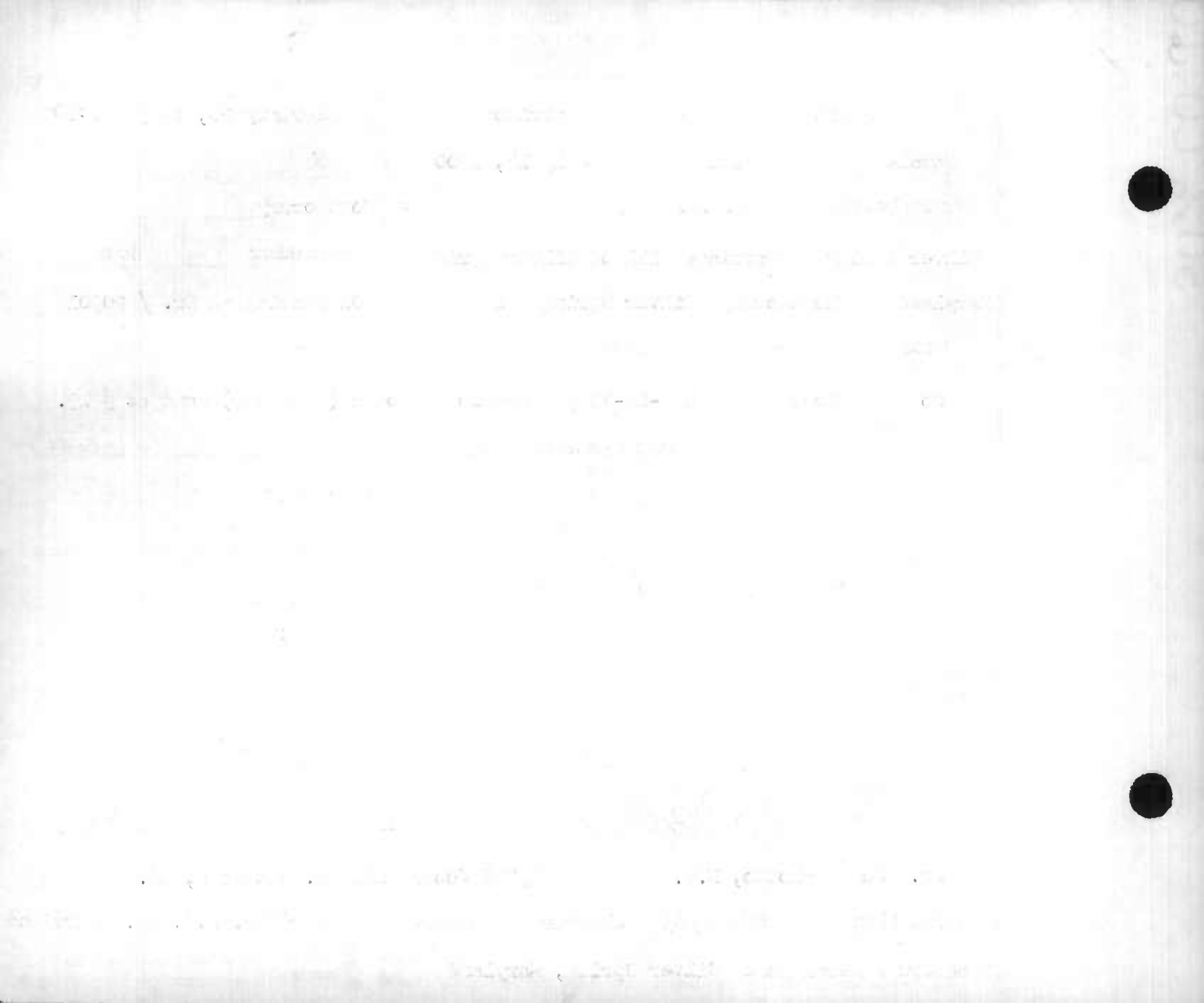
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Nan G. Harrison				2a. DATE OF DEATH MONTH DAY YEAR February 20, 1985		2b. HOUR 5:30a.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 14, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill of Silver Spring		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 801 Buckingham Dr. / 20901		14. FATHER'S NAME FIRST MIDDLE LAST Otto - Grupp		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna - Fey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 188-16-7985		17. INFORMANT ADDRESS Charlotte Young (Daughter) Same as # 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Arteriosclerotic Heart Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1-10 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-80 1985 to present , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 1-10 1985 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death.							
22b. SIGNATURE John Galotto				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Feb/20/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John Galotto, M.D.				22e. ADDRESS 5225 Pooks Hill Rd. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb/20/85		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G. Co., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Silver Spring, Maryland				25. DATE REC'D. BY REGISTRAR FEB 22 1985			
				25. REGISTRAR'S SIGNATURE John Davidson			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HASIN A HASHMI			2a. DATE OF DEATH MONTH DAY YEAR 2 5 85			2b. HOUR 7¹³ AM			
1. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 3, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Herndon MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADOLESCENT HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FINANCIAL MGR.		12b. KIND OF BUSINESS OR INDUSTRY COMSAT	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN VIRGINIA FAIRFAX GREAT FALLS			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 12002 HOLLY CREST CT. 99999				
14. FATHER'S NAME FIRST MIDDLE LAST BASHIR AHMAD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FATIMA KHATOON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 397-36-5188		17. INFORMANT ADDRESS SHAHID HASHMI 11834 GORA DR., POTOMAC, MD.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiogenic Shock

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) **Myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Coronary Artery Disease**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**35-45 min**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

9a. DATE OF OPERATION 10/20/85		10. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardiogenic Shock		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/4 , 19 85 , to 2/5 , 19 85 , that (I) (we) last saw the deceased alive on 2/5 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dennis Friedman		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS FRIEDMAN				22e. ADDRESS 13-15 EMB DEER PARK DR, GAITHERSBURG			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/7/85		23c. NAME OF CEMETERY OR CREMATORY ARNON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE GREAT FALLS FAIRFAX VIRGINIA	
24. FUNERAL DIRECTOR NAME BERKLEY GREEN 721 ELDEN ST., HERNDON, VA				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 11 1985 Julia Davidson-Randall			

BOOK ONE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Cuyler A Hawkins			2a. DATE OF DEATH MONTH DAY YEAR 2 24 85		2b. HOUR 10:15A	
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 10 13 98	6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? MONTGOMERY MD.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD	13b. CITY OR TOWN Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 623 Lincoln St. 20850		
14. FATHER'S NAME FIRST MIDDLE LAST William King	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTIE COPELAND			ADDRESS 13015		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, (NO, (UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-32-1449	17. INFORMANT ERMA Sullivan (Daughter) Morningside Ln Silver Spring Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Jaund.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) Diabetes Mellitus - Arterial Hypertension - Atherosclerosis						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from January 19 81 to Feb. 24 19 85 , that (I) (we) lost saw the deceased alive on February 23 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Glenn G. Brannan		DEGREE MD			22c. DATE SIGNED 2-24-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUGO G. GRAZIANI		22e. ADDRESS 717 PERSHING DR S.S. MD 20910				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 3-1-85	23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laytonsville Montg Md.		
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS Rockville MD		25a. DATE REC'D. BY REGISTRAR 2 28 1985		
		25b. REGISTRAR'S SIGNATURE Julia Davidson				

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>James Woodrow Haynes Sr.</i>										2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> <i>Feb 8</i> 19 <i>88</i> MONTH DAY YEAR	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Sept 7, 16 68</i>	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <i>19</i>	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <i>Feb 8</i> 19 <i>88</i> MONTH DAY YEAR		2b. HOUR <i>13</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>12468 Viers Mill Rd</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>retired Accountant</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>MD</i>			13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>12468 Viers Mill Rd</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry P. Haynes</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary O. Talley</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>578-12-6677</i>		17. INFORMANT ADDRESS <i>Carol R. Haynes same as 13e</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial disc</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>None</i>											
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) <i>M.D. Dep</i>						DATE SIGNED <i>FEB 8 1988</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers</i>			ADDRESS <i>1919 Seminary Rd. Silver Spring, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/11/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Memorial Park</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville, Maryland</i>			
24. FUNERAL HOME <i>Tyson Wheeler Funeral Home, Inc.</i> ADDRESS <i>1331 Rockville Pike, Rockville, Md. 20852</i>						25a. DATE REC'D. BY REGISTRAR <i>FEB 13 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Carroll H. Riddell</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH (172) FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		ESTIMATED <input checked="" type="checkbox"/> 2 4 85		2b. HOUR 5:00 A M	
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Stephenson Hays		3. SEX Female		4. RACE White		5. DATE OF BIRTH Mar. 15, 1920	
6. AGE (IN YEARS) 64 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OH		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6906 Oakridge Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Edward Stephenson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosalind Longley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 283-16-2975	
17. INFORMANT ADDRESS Gaithersburg, MD 20879		17. INFORMANT Stephen L. Hays		24009 Bush Hill Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Cirrhosis of Liver.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE John Tauber		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER Bethesda, Md.		DATE 2-4-85 SIGNED	
EXAMINER'S NAME (TYPE OR PRINT) John Tauber		ADDRESS 8218 Wisconsin Ave					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/7/85		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, MD	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D BY REGISTRAR FEB 11 1985			

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

Cora E. Hazes

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Cora Hazes			2a. DATE OF DEATH MONTH DAY YEAR 02 19 85			2b. HOUR 8:25 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 10, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
12. CITY OR TOWN OF DEATH Bethesda		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		15. KIND OF BUSINESS OR INDUSTRY Law Office	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DC 13b. COUNTY None 13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5425 Western Ave. NW 20015				
14. FATHER'S NAME FIRST MIDDLE LAST Clarence A. Woodward			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Baker			16. ADDRESS Sil. Spg. MD 20910			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 173-14-7412		17. INFORMANT Elizabeth A. Eastman 8834 Woodland Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Chronic lung disease, congestive heart failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> 19 <u>85</u> to <u>2-19</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>2-19</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James H. Brodsky MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-20-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James H. Brodsky, M.D.				22e. ADDRESS 4701 Willard Ave. CC, MD 20815					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/21/85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, MD			
24. FUNERAL DIRECTOR NAME Josph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE FEB 26 1985 <u>John T. Jordan-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert ROBERT				MIDDLE A. 4.		LAST Hechtman HECHTMAN		2a. DATE OF DEATH MONTH 2 DAY 12 YEAR 85 February 12, 1985		2b. HOUR 4 A M		
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH April DAY 22 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS 73 DAYS YRS.		IF UNDER 24 HRS HOURS 4 MIN. A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.						
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE NURSG. HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer (R)		12b. KIND OF BUSINESS OR INDUSTRY Civil Engineer				
13a. STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Reston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1612 Chimney House Road 99999				
14. FATHER'S NAME FIRST Abraham MIDDLE Hechtman				15. MOTHER'S MAIDEN NAME FIRST Maren MIDDLE Olson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 532-01-3189		17. INFORMANT Sarah Jane Hechtman ADDRESS Same as item 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain aneurysm DUE TO, OR AS A CONSEQUENCE OF ABSCISS (b) HEAVY DUE TO, OR AS A CONSEQUENCE OF HEAVY (c) HEAVY										APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH 6 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. hemorrhage - on blood												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) 1/15/85 85 2/12 85								
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1811 P + Phylip St, Olney 20832								
22a. I certify that (I) (this hospital) attended the deceased from 1/12/85 to 2/12/85 , that (I) (we) last saw the deceased alive on 2/12/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I we) (did) (did not) view the body after death.										22c. DATE SIGNED 2/12/85		
22b. SIGNATURE H. H. H. H. H.				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. H. H. H. H.				22e. ADDRESS 1811 P + Phylip St, Olney 20832								
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 2/14/85		23c. NAME OF CEMETERY OR CREMATORY Lee		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.						
24. FUNERAL DIRECTOR NAME Cunningham Funeral Home, Inc.		ADDRESS Alex., Va.		DATE REC'D. BY REGISTRAR FEB 20 1985		REGISTRAR'S SIGNATURE Julia Davidson-Randall						

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 1 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LILLIAN ROSINA HECK			2a. DATE OF DEATH MONTH DAY YEAR 2/11/85			2b. HOUR 5:55 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4 10 2		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. COUNTY Montgomery		13d. CITY OR TOWN Silver Spring		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE 10011 Grayson Avenue 20901	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK NMI Frank		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BELLE NMI PHILLET							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-44-7127		17. INFORMANT ADDRESS Alfred F. Heck Husband Same as 13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 hr.

7 yr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

Diabetes mellitus, Hypertension

19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/8</u> , 19 <u>85</u> , to <u>2/11</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/11</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Kenneth M. Lindgren</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth M. Lindgren, MD				22e. ADDRESS 7600 Carroll Avenue Takoma Park, Md.			

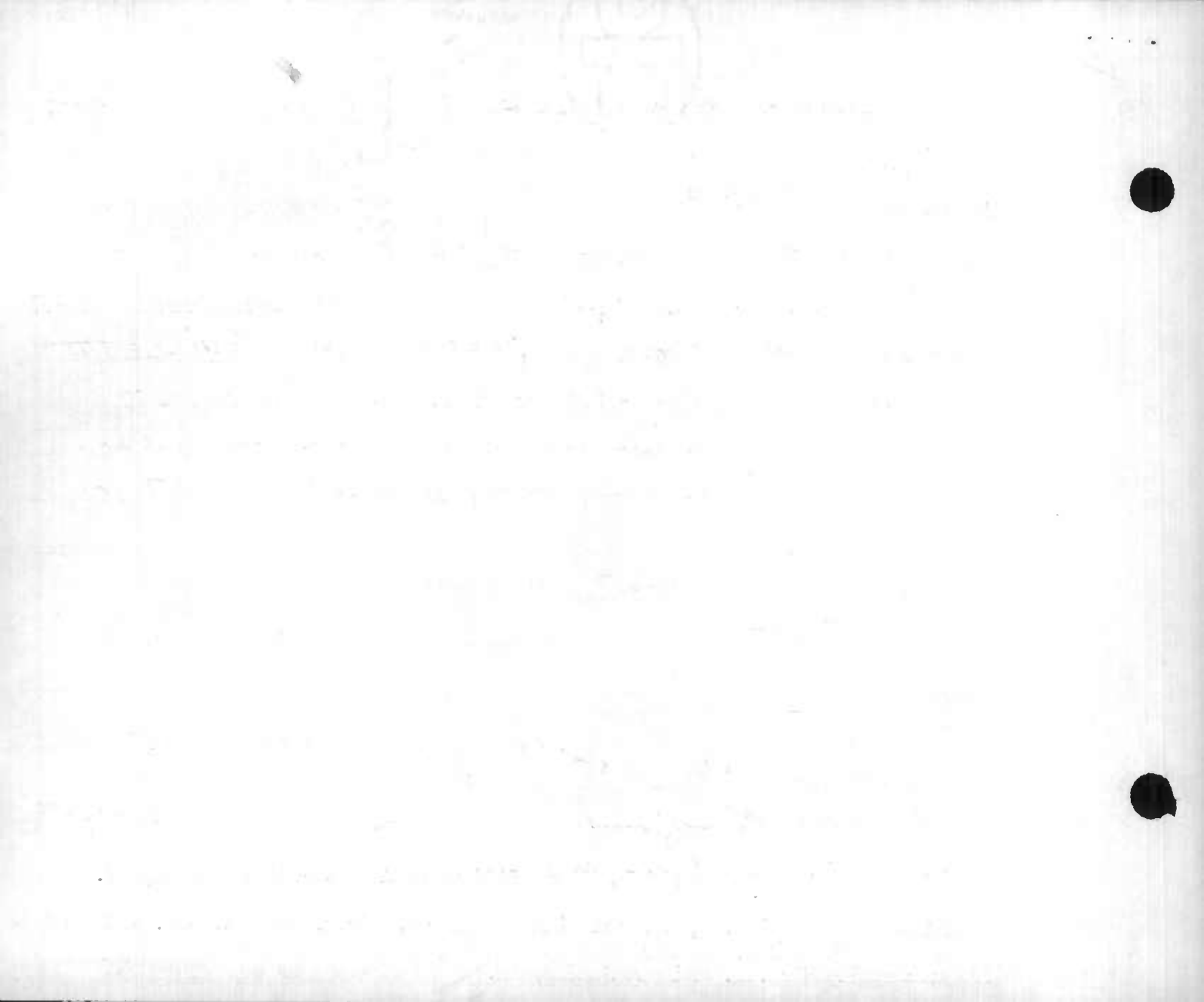
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 14, 1985		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Maryland	
24. FUNERAL DIRECTOR NAME Francis J. Collins				25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
500 University Blvd., W. Silver Spring, Md.							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, 1980 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.



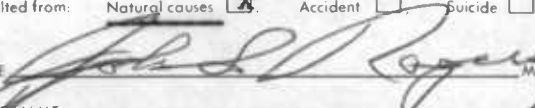
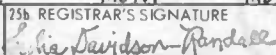
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Film G601 item 1

FOR
1- STATE 3/6/85 rja
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST DOROTHY JONES HEDRICK			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2/5 19 85			2b. HOUR 9:30 A. M.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sep. 7, 1915	6. AGE (IN YEARS) LAST BIRTHDAY 69 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2/5 19 85			7d. HOUR 9:30 A. M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9207 Glenville Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCHOOL SYSTEM AID			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9207 Glenville Road 20901			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN B. ROGERSON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH DAVIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 272-05-3627			17. INFORMANT DAUGHTER 8009 HILTON ROAD MELINDA WRIGHT GAITHERSBURG., MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN DEATH		
									20879		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 						TITLE (SPECIFY) Deputy MEDICAL EXAMINER			DATE SIGNED 2/5/85		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.						ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/7/85		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR FEB 11 1985			25b. REGISTRAR'S SIGNATURE 		
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

BP _____

05:00
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05:00
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HEDIN 101

ESMOT

THYROID

Female White Sep. 7, 1915 69

Mentzger County

x

2507 Glenville Road

Silver Spring

9507 Glenville Road

Silver Spring

Manufacturing

500-1776.4

Acute myocardial disease.

alone.

enough.

2004

1

X _____

5/2/05

119 Seminary Road

Silver Spring, Montgomery, Md.

John A. Rogers, M.D.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 1 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Abbott Heine			2a. DATE OF DEATH MONTH DAY YEAR February 25, 1985		2b. HOUR 5:04 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 3 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Central Int. Agency	12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE 14502 Elmhan Court 20906					

14. FATHER'S NAME FIRST MIDDLE LAST Joseph Heine		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Montgomery	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII		16b. SOCIAL SECURITY NO. 577-10-0842	
17. INFORMANT Marjorie Heine		ADDRESS Silver Spring 14502 Elmhan Ct. Md. 20906	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Overwhelming Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>trauma shock system</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>post op wound infection</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hr. 29 day 32 day
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION 1/11/85	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED P recurrent inguinal hernia	19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/11/85 to 2/25/85, that (I) (we) last saw the deceased alive on 2/25/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.			
22b. SIGNATURE <u>M. E. L. L. L.</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/26/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. E. L. L. L.		22e. ADDRESS 3915 FERRAND DR. Wheaton, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Feb. 26 1985	23c. NAME OF CEMETERY OR CREMATORY Lee Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.
24. FUNERAL DIRECTOR NAME COLUMBIA MORTUARY SERVICES		25. DATE REC'D. BY REGISTRAR MAR 04 1985	26. REGISTRAR'S SIGNATURE John Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.



General Inv. Agency
1405 Main Court
2000

General Inv. Agency
1405 Main Court
2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Elizabeth L. Helfand		Feb. 17, 1985		5:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))	IF UNDER 1 YEAR	
Female	White	12 25 1904	80 YRS.	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Russia	USA	Montgomery County, MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Rockville	Potomac Valley Nursing Center		Housewife	-----	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Montgomery	Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	259 Congressional Lane	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Jacob Lattash		Jenny (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
No	160-09-8205	Joyce Savell; 19 Hardwicke Pl., Rockville Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension (15 mmHg)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>General arteriosclerotic disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio-sclerotic heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8 Feb 85</u> , to <u>17 Feb 85</u> , that (I) (we) last saw the deceased alive on <u>8 Feb 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
PAUL T. NOONE		MD		12 Feb 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
PAUL T. NOONE, M.D.		50 West Edmonston Drive; Rockville Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	2-18-1985	Judean Mem. Gardens		Olney, Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Danzansky-Goldberg Chapels; 1170 Rockville Pike		FEB 21 1985		Julia Davidson-Randall	

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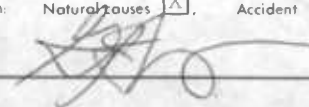

1. The first part of the report is a summary of the work done during the year. It includes a list of the projects completed and a brief description of the results. The second part is a detailed account of the work done on each project. It includes a description of the methods used, the results obtained, and a discussion of the significance of the work. The third part is a list of the publications resulting from the work. The fourth part is a list of the names of the persons who have contributed to the work. The fifth part is a list of the names of the persons who have been employed during the year. The sixth part is a list of the names of the persons who have been consulted during the year. The seventh part is a list of the names of the persons who have been assisted during the year. The eighth part is a list of the names of the persons who have been supervised during the year. The ninth part is a list of the names of the persons who have been directed during the year. The tenth part is a list of the names of the persons who have been advised during the year. The eleventh part is a list of the names of the persons who have been consulted during the year. The twelfth part is a list of the names of the persons who have been assisted during the year. The thirteenth part is a list of the names of the persons who have been supervised during the year. The fourteenth part is a list of the names of the persons who have been directed during the year. The fifteenth part is a list of the names of the persons who have been advised during the year.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 05619	
1. DECEASED NAME (TYPE OR PRINT) Charles Edward Hensel						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2/ 2/ 1985		2b. HOUR 9:40 A			
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 3, 1947	6. AGE (IN YEARS) LAST BIRTHDAY 37 YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 2/ 5/ 1985		7d. HOUR A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 456 Girard Street, Apt. 201				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEERING AIDE		12b. KIND OF BUSINESS OR INDUSTRY CO. GOV'T.			
13a. STATE Md.										13b. CITY OR TOWN MONTGOMERY	
13c. CITY OR TOWN GAITHERSBURG										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 456 GIRARD AVE.										20877	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM M. HAENSZEL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN CLARK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES) -----		16b. SOCIAL SECURITY NO. 220-54-1163		17. INFORMANT WILLIAM M. HAENSZEL		ADDRESS 341 e. Hawthorn Ave WHEATON, ILL. 60187			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure disorder DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) -----										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Assistant				DATE SIGNED 2/6/85			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE FEB. 7, 1985		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE P.G.C. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS W. W. CHAMBERS CO. INC. SILVER SPRING, Md.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE 			

W.D. & H.O. WILLS



GEORGE W. WILLS

W.D. & H.O. WILLS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

05620

1. DECEASED NAME (TYPE OR PRINT) Joseph Ferdinand Herrmann			2a. DATE KNOWN OF DEATH ESTIMATED Feb. 1 1985			2b. HOUR 9 P		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Jan 17, 1935	6. AGE [IN YEARS LAST BIRTHDAY] 50 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD Feb. 2 1985	7d. HOUR 9 P	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Accred from 4001 Mount Pelier Rd		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD				13b. COUNTY Montg.		13c. CITY OR TOWN Spk.		
14. FATHER'S NAME FIRST MIDDLE LAST FERDINAND KARL HERRMANN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL ELIZABETH DARBY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 579-62-5534		17. INFORMANT 19777 GLADE DRIVE ETHEL D. HERRMANN SILVER SPRING, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a: None								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 2 1 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot self				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE George Ave Mt Pelier Rd Rockville Montg MD				
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				TITLE (SPECIFY) Dep				
ACTUAL SIGNATURE John S. Rogers		M.D. Dep		MEDICAL EXAMINER		DATE SIGNED Feb 2 1985		
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, M.D.		ADDRESS SILVER SPRING, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2/3/85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR FEB 7 1985		25b. REGISTRAR SIGNATURE Rebecca H. H. H.		
500 UNIVERSITY BLVD., W., SILVER SPRING, MD								

UNRECORDED

420

WYLAND

YES

279-62-2834

HERMAN

ETHEL

ELIZABETH

YARD

ETHEL D. HERMAN SILVER SPRING, MD

1211 GLADE DRIVE

500 UNIVERSITY BLVD., W. SILVER SPRING, MD

FRANCIS J. COLLINS

CREATION

213/55

METROPOLITAN CEMENTORY

ALEXANDRIA

VIRGINIA

JOHN S. ROGERS, M.D.

201111 SPRING, WYLAND

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
JEANNE S. Hess				2/23/85		10 ³⁰ A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Caucasian		April 5, 1895		89		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Florida		United States				Montgomery County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		SUBURBAN HOSP.		Homemaker		Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE			
Maryland		Montgomery Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20815 3513 Leland Street			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Adolphe		Staebler		No		080 14 6948		Daughter	
								Marjorie Jeanne Brett Same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Irreversible Respiratory Failure								48 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) LOBAR Pneumonia								72 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from February 23, 1985, to February 23, 1985, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) know the body after death.									
22b. SIGNATURE				DEGREE		22c. DATE SIGNED			
James E. Wilson, Jr.				M.D.		2/23/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
James E. Wilson, Jr. M.D.				1125 Rockville Pike, Rockville, Md. 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Cremation		Feb 25, 1985		Metropolitan Crematory Alexandria, Virginia		CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				FEB 28 1985		A. Davidson-Randall			

MEDICAL CERTIFICATION

2/29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 410-326-7000.

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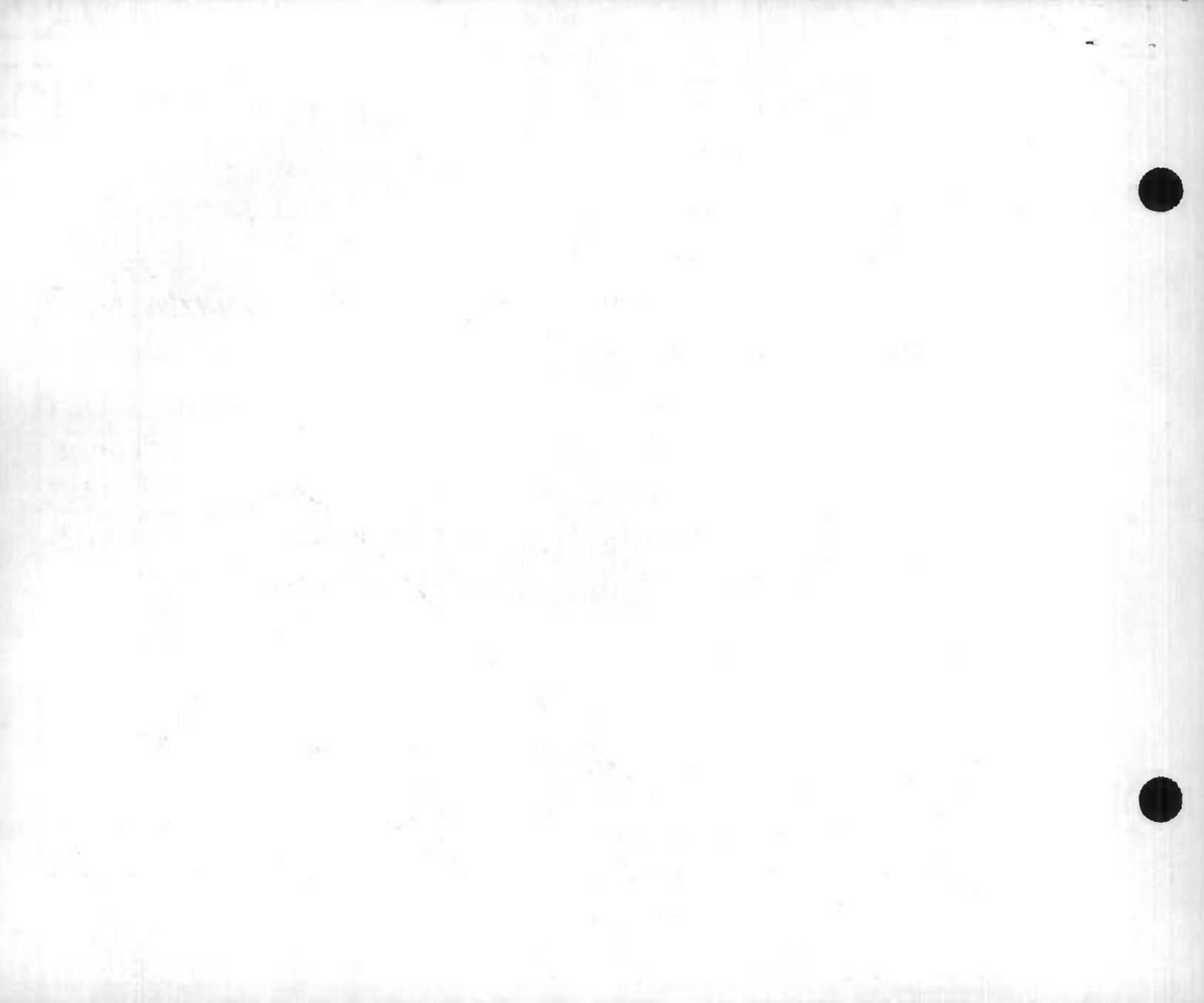
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 2 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EVERETT L. HESSLER			2a. DATE OF DEATH MONTH DAY YEAR Feb 4, 1985			2b. HOUR 10 39 A.M.			
3. SEX Male		4. RACE Cauc		5. DATE OF BIRTH MO DAY YEAR Sept. 8, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN) Washington, DC		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
12. CITY OR TOWN OF DEATH Bethesda		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp				14. USUAL OCCUPATION (INCLUDING WORKING LIFE) Electrical Installer		15. KIND OF BUSINESS OR INDUSTRY Electrical Contracting	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. CT - 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17. STREET ADDRESS 5420 CONN AVE, NW #411		18. ZIP CODE 20015					
19. FATHER'S NAME FIRST MIDDLE LAST Charles C. Hessler		20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Stewart							
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		22. SOCIAL SECURITY NO 578-05-83554		23. INFORMANT Ora B. Hessler, same as #13					
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right lower lobe pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive heart failure</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days 10 years 5 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>hypertension, Chronic atrial fibrillation</u>									
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE					
35. I certify that (I) (this hospital) attended the deceased from <u>Nov 84</u> 19 <u>84</u> to <u>Feb 4</u> 19 <u>85</u> , that (I) (we) lost <u>view</u> the deceased alive on <u>Feb 4</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
36. SIGNATURE <u>James F. McMurry Jr. M.D.</u>		37. DEGREE M.D.		38. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		39. DATE SIGNED 12/4/85			
40. PHYSICIAN'S NAME (TYPE OR PRINT) James F. McMurry Jr. M.D.		41. ADDRESS 6318 Democracy Blvd, Bethesda, MD							
42. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		43. DATE Feb. 8 1985		44. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		45. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
46. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814				47. DATE REC'D. BY REGISTRAR FEB 8 1985		48. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			



Dr. Rogers ok'd ERMD to sign cert.
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/83
 (VRA 15, 4)

FOR
 1- STATE
 REGISTRAR

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Eunice Dean Hewitt</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2 12 85</i>		2b. HOUR <i>0657</i> M	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 14 1911</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Barbados</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Barbados</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
10. CITY OR TOWN OF DEATH <i>Takoma Pk. Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wash. Adventist Hosp.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Practical Nurse</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Medical</i>		13. STREET ADDRESS / ZIP CODE <i>902 Fair Oak Ave. 20783</i>		
10a. STATE <i>Md.</i>		10b. COUNTY <i>P.G.</i>		10c. CITY OR TOWN <i>Hyattsville</i>		
11a. FATHER'S NAME FIRST MIDDLE LAST <i>Information not available</i>		11b. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Albertha Cumberbatch</i>		11c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>15-50-3970</i>		17. INFORMANT ADDRESS <i>Jasmine Hewitt, daughter, 902 Fair Oak Ave., Hyattsville, Maryland</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

cervical carcinoma

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		70a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Frank Listello MD</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>2/12/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>FRANK LISTELLO</i>		22e. ADDRESS <i>7600 Carrol Ave., Takoma Park, Md.</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Feb. 16, 85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>George Washington</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Adelphi, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>McGuire Funeral Service, Inc., Washington, D.C.</i>				25. DATE REC'D. BY REGISTRAR <i>FEB 21 1985</i>			
25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) CATHERINE BRONSON HIGGINS					2a. DATE OF DEATH MONTH 2 DAY 15 YEAR 85				2b. HOUR 6:05 PM			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 10 DAY 27 YEAR 09		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School system				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY PG 13c. CITY OR TOWN BELTSVILLE					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10508 43 RD AVENUE 20705					
14. FATHER'S NAME FIRST George MIDDLE Bronson LAST Berkstrasser					15. MOTHER'S MAIDEN NAME FIRST Meige MIDDLE Berkstrasser LAST Berkstrasser							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 217 46 6271		17. INFORMANT ADDRESS Francis Higgins (Husband) Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pneumonia of Rt. Lobe DUE TO, OR AS A CONSEQUENCE OF (b) Asthenia Cardiovascular of Rt. Lobe DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c:												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2/11/85 , 19 85 , to 2/15/85 , 19 85 , that (I) (we) lost saw the deceased alive on 2/13/85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) close the body after death.												
22b. SIGNATURE H. L. MARTER				DEGREE MD				22c. DATE SIGNED 2/16/85				
22b. PHYSICIAN'S NAME (TYPE OR PRINT) H. L. MARTER				22c. ADDRESS 7610 Carroll Ave, Takoma Park MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 2/18/85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland				
24. FUNERAL HOME OR OTHER INSTITUTION NAME Francis Casch's Sons Funeral Home, P.A. ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781						25a. DATE REC'D. BY REGISTRAR FEB 21 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 2 5

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gerald Albert Hilty			2a. DATE OF DEATH MONTH DAY YEAR 02/04/85		2b. HOUR 6 A M
3. SEX male	4. RACE cauc.	5. DATE OF BIRTH MONTH DAY YEAR 08 - 10 - 1911	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IDAHO	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICAL ENGINEER ELECTRICAL		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY MONTG.	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JESSE HILTY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL BAKER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 564-481443		17. INFORMANT VIOLETA C. HILTY (SAME AS #13)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, colon pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>fever</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION 1-30-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer resected		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-26</u> , 19 <u>85</u> , to <u>2-4</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2-3</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James P. McCarrick MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-4-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James P. McCarrick		22e. ADDRESS 809 Vicks Mill Rd. Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 2-5-1985	23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PG.C. Md.	
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS CO.		ADDRESS SILVER SPRING, MD		25a. DATE REC'D. BY REGISTRAR FEB 06 1985	
		25b. REGISTRAR'S SIGNATURE Julia Swindon-Randall			

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 2 6

FOR
1 - STATE
REGISTRAR

REG. NO.

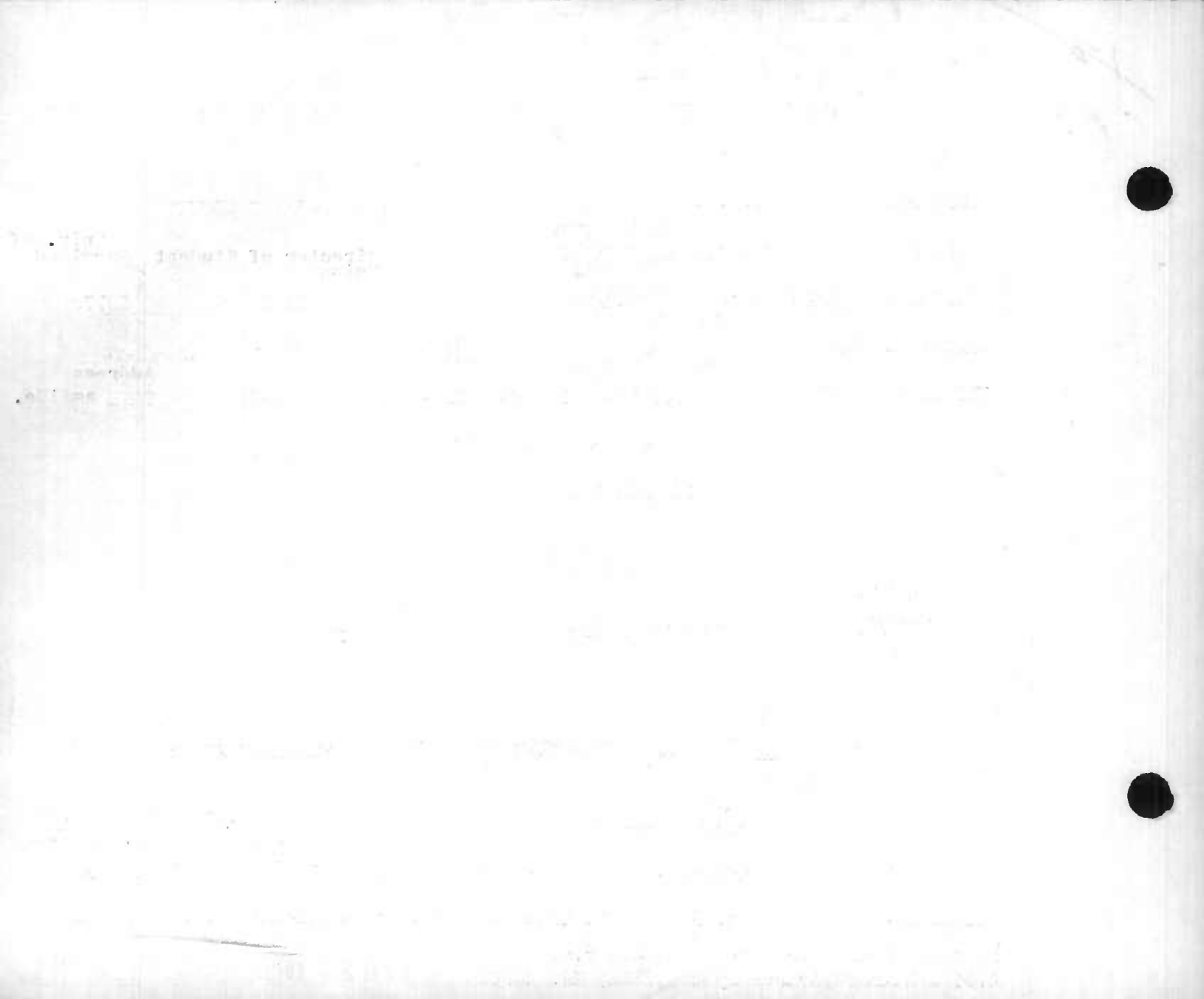
1. DECEASED NAME (TYPE OR PRINT) WILLIAM LUTHER HOFF			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 22, 1985		2b. HOUR 1:16P M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JANUARY 30, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Director of Student Union		12b. KIND OF BUSINESS OR INDUSTRY Univ. of Maryland
13a. STATE MARYLAND	13b. COUNTY PRINCE GEORGE	13c. CITY OR TOWN GREENBELT	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 71-E RIDGE ROAD 20770	
14. FATHER'S NAME (FIRST MIDDLE LAST) MARTIN L. HOFF		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Blanche Crothers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES ARMY WWII		16b. SOCIAL SECURITY NO. 220-10-0623		17. INFORMANT ADDRESS MRS AMELIA A. HOFF (WIFE) Address SAME as #13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRA ABDOMINAL SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: S/P MI					
19a. DATE OF OPERATION 1/29/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SPLENIC ABSESS		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 30, 1984, to FEBRUARY 22, 1985, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on FEBRUARY 22, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE Matthew Brenner MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Matthew Brenner		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/26.85		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cremetory	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G. Maryland		23e. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cremetory			
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR FEB 28 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, there is any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 2 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FANNIE			FIRST HOFFMAN			LAST			2a. DATE OF DEATH MONTH DAY YEAR 2-19-85			2b. HOUR 11¹⁰ P.M.		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR March 14 1905			6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia			7b. CITIZEN OF WHAT COUNTRY? USA.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			12b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Chevy Chase			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2711 Colston Drive 20815		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Smith						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 578 22 4843			17. INFORMANT ADDRESS Clara Gordon- 2711 Colston Dr. Maryland Chevy Chase								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Large pulmonary tumor												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 4 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Moderate Dementia, Right Mastectomy (1974)														
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9/18/19 84 to 2/19/19 85								
22a. I certify that (I) (this hospital) attended the deceased from 2/14/19 85 , and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Stanley Cutler, MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED 2-20-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY CUTLER						22e. ADDRESS 6121 MONTROSE ROAD ROCKVILLE, MD 20852								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 20, 1985			23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Ives-Pearson F. Homes, Falls Church, Va 22046														
25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE		

BP

20% COTTON

CHAMPION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low return is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pay to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Francis W. Holman SR.						2a DATE OF DEATH MONTH DAY YEAR FEB. 15, 1985		7b HOUR P 12:07 M	
3 SEX Male		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR 10 26 1905		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MEDICAL DOCTOR		12b KIND OF BUSINESS OR INDUSTRY SURGICAL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND						13b COUNTY MONTGOMERY		13c CITY OR TOWN ROCKVILLE	
14 FATHER'S NAME FIRST MIDDLE LAST FRANCIS P. HOLMAN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FELICIA SHULER		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 14620 CHESTERFIELD RD. 20853			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT FRANCIS W. HOLMAN, JR.		ADDRESS SAME AS 13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarct, anteroseptal, old, healed</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <u>Myocardial infarct, anteroseptal, old, healed</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Julian T Coggin MD				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED Feb 16, 1985	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Julian T Coggin, MD				22e ADDRESS Montgomery General Hosp Olney MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 2-18-85		23c NAME OF CEMETERY OR CREMATORY HAMILTON CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE NEPTUNE, MONMOUTH, NEW JERSEY			
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD, 20901				25a DATE RECD BY REGISTRAR 25b REGISTRAR'S SIGNATURE FEB 26 1985					

MEDICAL CERTIFICATION

BURIAL 2-18-85 HAMILTON CEMETERY
 FRANCIS J. COLLINS
 500 UNION BLVD., W. SPRING, MD. 20901
 FEB 24 1985
 NEW JERSEY

XX

YES
 WHITE
 147-34-2911
 FRANCIS W. HOLLAND, JR.
 SAME AS 126
 FELICIA
 HOLLAND
 F.
 MONTGOMERY
 ROCKVILLE
 1-620 CHESTERFIELD RD. 20852

MEDICAL RECORD SUBMIT

USA
 CAUCASIAN
 10 28 1902
 XX

SOUTH CAROLINA

980917

RECEIVED
 10-1-85



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 2 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna E. Holsinger			2a. DATE OF DEATH MONTH DAY YEAR 2 14 85			2b. HOUR 1533 M				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9/6/1894		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 121 LAYTONSVILLE ROAD 20877		
14. FATHER'S NAME FIRST MIDDLE LAST JOSIAH NELSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA NELSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-10-1522D		17. INFORMANT MRS. BELLA STRUNTZ, 121 LAYTONSVILLE ROAD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary artery disease (b) Anterior wall (c) myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE COOK 77 det					
22a. I certify that (I) (the hospital) attended the deceased from 2/14/85 to 2/14/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If certified, did not view the body after death.)										
22b. SIGNATURE Thos G. Ward			22c. DATE SIGNED 2/14/85			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward			22e. ADDRESS 6116 Robinson, Bethesda, 20817	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/17/85		23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ECKHART ALLEGANY MD			
24. FUNERAL DIRECTOR SOWERS FUNERAL HOME					25a. DATE REC'D. BY REGISTRAR FEB 19 1985					
60 W. MAIN ST. FROSTBURG					25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



EXHIBIT

101-1

DATE	TIME	LOCATION	BY
10/1/54	10:00 AM	NEW YORK	JOHN EDGAR HOOVER

RECEIVED

TO THE DIRECTOR, FBI, FROM THE SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

[Large block of extremely faint, illegible text, likely a memorandum or report body.]

APPROVED: [Illegible Signature] SPECIAL AGENT IN CHARGE

FORWARDED: [Illegible Signature] ASSISTANT ATTORNEY GENERAL



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 3 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Evelyn B Hoopes</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2 6 85</i>		2b. HOUR <i>3:45 AM</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>8 1 96</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>H.M.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>HOMEMAKER</i>
13a. STATE <i>MD</i>			13b. COUNTY <i>MONTGOMERY</i>	13c. CITY OR TOWN <i>KENSINGTON</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>CHARLES BROWN</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ADA ETZLER</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>220-32-1381</i>		17. INFORMANT <i>BETTY GOODING</i> ADDRESS <i>SAME AS 13 DAUGHTER</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic obstructive lung disease years</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic heart disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <i>Arteriosclerotic heart disease</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>4/6</i> 19 <i>85</i> , to <i>2/6</i> 19 <i>85</i> , that (1) (we) lost saw the deceased alive on <i>4/6</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>B. N. ROSENBAUM, M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/6/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B. N. ROSENBAUM</i>		22e. ADDRESS <i>3720 FARRAGUT AVE KENSINGTON, MD 20895</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>	23b. DATE <i>2/9/85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>METROPOLITAN CREMATORY</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>ALEXANDRIA VIRGINIA</i>
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 11 1985</i>	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

WILLIAM W. B. 1871

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Film G 5 Item 5

FOR 5/23/85 rja
1- STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 3 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Shao Ti Hsu			2a. DATE OF DEATH MONTH DAY YEAR Feb 2, 1985		2b. HOUR M
3. SEX Male	4. RACE Oriental	5. DATE OF BIRTH MONTH DAY YEAR May 28, 1916	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 602 Ivy League Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professor		12b. KIND OF BUSINESS OR INDUSTRY U. of Md.
13a. STATE Md		13b. COUNTY Montg	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 602 Ivy League Lane 20853
14. FATHER'S NAME FIRST MIDDLE LAST Unk		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 010-24-9965		17. INFORMANT ADDRESS Mrs Charlotte Hsu Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CENTRAL NERVOUS SYSTEM DISORDER WITH FEATURES OF ALZHEIMER'S DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) AND AMYOTROPHIC LATERAL SCLEROSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 DAYS 1-2 YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from APRIL 19 84 to FEBRUARY 19 85, that (I) (we) last saw the deceased alive on JANUARY 31, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Lawrence D. Marcus M.D.				22c. DATE SIGNED 2/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE D. MARCUS M.D.				22e. ADDRESS 10313 GEORGIA AVENUE SILVER SPRING, MARYLAND 20902	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2-5-85	23c. NAME OF CEMETERY OR CREMATORY Francis Brown F/H		23d. LOCATION CITY OR TOWN COUNTY STATE Somerville, MA
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Wash. St. Rockville, Md. 20850		25a. DATE REC'D. BY REGISTRAR FEB 06 1985	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8505632

FOR 1- STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) SHERI Sue HUDGINS		2a. DATE OF DEATH MONTH DAY YEAR February 3, 1985	
3. SEX Female		2b. HOUR 2:56 am	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 3 days	
5. DATE OF BIRTH MONTH DAY YEAR January 31, 1985		IF UNDER 1 YEAR MONTHS DAYS 0 3	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		IF UNDER 24 HRS. HOURS MIN. 0 3	
7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13c. COUNTY Montgomery		13d. STREET ADDRESS 11717 Ashley Drive 20852	
13e. CITY OR TOWN Rockville		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Penelope S. Shanholtz	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Mayo Hudgins		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Jean A. Hudgins same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 67 HOURS	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AORTIC ATRESIA WITH Hypoplastic left Valve + Hypoplastic Mitral Valve			
DUE TO, OR AS A CONSEQUENCE OF (c) CYANOTIC CONGENITAL HEART DISEASE			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-31 , 19 85 , to 2-3 , 19 85 , that (I) (we) last saw the deceased alive on 2-3 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Wilma Dario Dayrit M.D.		22c. DATE SIGNED Feb. 3, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILMA DARIO DAYRIT M.D.		22e. ADDRESS NEONATAL HEALTH SERVICES P.C. 5110 RIDGEFIELD ROAD, BETHESDA, MD 20816	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/6/85	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION Brentwood, Maryland STATE	
24. FUNERAL HOME Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR FEB 7 1985	
25b. REGISTRAR'S SIGNATURE <i>Wheeler</i>			

BP

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February 3, 1955

SHIRLEY and JUDITH

Longmont, Colorado

Longmont General Hospital

Olney

Longmont General Hospital

Longmont

Longmont

Longmont

Longmont General Hospital

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Longmont

Longmont



20% COTTON

Longmont General Hospital, Longmont, Colorado

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 3 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RUTH A HUDNUT			2a. DATE OF DEATH MONTH FEB DAY 7 YEAR 1985			2b. HOUR 7:20 A.M.	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH APRIL DAY 4 YEAR 1893		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD		13b. COUNTY MONT.		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST FRANK MIDDLE LAST HUDNUT		15. MOTHER'S MAIDEN NAME FIRST EMILY MIDDLE LAST ALLISON		13e. STREET ADDRESS / ZIP CODE 507 PHILADELPHIA AVE 20912			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-44-1935		17. INFORMANT ADDRESS A.P. CRENSHAW III 1110 VERNONT AVE N.W. DC			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 2 1984 to late , that (I) (we) lost 2/6/85 above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Thos G. WAKO		22c. ADDRESS 6116 Robinson Rd Bethesda 20817		22d. DATE SIGNED 2/7/85		22e. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb-11-1985		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda MD	
24. FUNERAL DIRECTOR (NAME) John F. Anderson, Jr.		24b. ADDRESS 257 Canal St. N.W. DC		25a. DATE BY REGISTRAR FEB 11 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general description of the project and its objectives. This section is followed by a detailed description of the methodology used in the study. The results of the study are then presented in a series of tables and figures. Finally, the conclusions of the study are discussed, along with some suggestions for further research.

The second part of the report is a detailed description of the methodology used in the study. This section is followed by a detailed description of the results of the study. The results are presented in a series of tables and figures. Finally, the conclusions of the study are discussed, along with some suggestions for further research.

The third part of the report is a detailed description of the results of the study. The results are presented in a series of tables and figures. Finally, the conclusions of the study are discussed, along with some suggestions for further research.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, no injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 3 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>William Henry Hunley</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2 12 85</i>			2b. HOUR <i>10⁵⁵ A.M.</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 1 1903</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONT</i> MD.				
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Pressman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>GPO</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>15320 Pine Orchard Drive # 2-B 20906</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Hunley</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Muir</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				
16b. SOCIAL SECURITY NO. <i>578-05-6854</i>			17. INFORMANT ADDRESS <i>Helen G. Hunley Wife Same as 13</i>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

LUNG CANCER

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>6/1</i> 19 <i>84</i> to <i>2/12</i> 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>2/12</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>2/12/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARK H. EIG</i>				22e. ADDRESS <i>9801 Georgia Ave. Silver Spring</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Feb. 15, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood Pr. Geo. Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>				ADDRESS <i>500 University Blvd., W. Silver Spring, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 19 1985</i>	
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



X



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST SHIRLEY MAY HUTCHINS				FEBRUARY 7, 1985			
3. SEX FEMALE				7b. HOUR 1:57 A M			
4. RACE WHITE				5. DATE OF BIRTH MONTH DAY YEAR MARCH 23, 1927			
6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.				7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.			
7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH BETHESDA				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			
12b. KIND OF BUSINESS OR INDUSTRY Gen. Conf. SDA							
13a. STATE MARYLAND				13b. COUNTY			
13c. CITY OR TOWN TAKOMA PARK				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST George Hutchins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 131-22-3987			
17. INFORMANT ADDRESS MRS. RUTH HUTCHINS				2023 LAKE PAGE LANE APOPKA, FLORIDA 32703			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated abdominal infection and possible gas gangrene DUE TO, OR AS A CONSEQUENCE OF (b) Massive hepatic neurosis due to (A) DUE TO, OR AS A CONSEQUENCE OF (c) Nodular pneumonia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 12 hours Days			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Pancreatic cancer with multiple metastasis to liver				12 months			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (he) (this hospital) attended the deceased from FEBRUARY 5, 1985, to FEBRUARY 7, 1985, that (we) (I) saw the deceased alive on FEBRUARY 7, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE			
22c. DATE SIGNED Feb. 8, 1985				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEVIN S. HUGHES, MD				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH 9000 ROCKVILLE PIKE, BETHESDA, MD 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 9, 1985			
23c. NAME OF CEMETERY OR CREMATORY George Washington Riggs Rd. Hyattsville, Takoma Funeral Home.				23d. LOCATION CITY OR TOWN COUNTY STATE Prince Geo. Co.			
25a. DATE REC'D. BY REGISTRAR FEB 11 1985				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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DATE-22-100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST R eulah Mae Inman			2a. DATE OF DEATH MONTH DAY YEAR Feb. 8, 1985		2b. HOUR 10:15 P M				
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR July 5, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11920 Fernshire Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11920 Fernshire Rd. 20879	
14. FATHER'S NAME FIRST MIDDLE LAST Fred S. Sutton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Colyott			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 497-20-1229			17. INFORMANT Barbara Inman			17. ADDRESS 11920 Fernshire Rd. Gaithersburg, Md. 20879			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiorespiratory arrestAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**5 min**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

coronary heart disease, peripheral vascular disease**years**

DUE TO, OR AS A CONSEQUENCE OF

(c)

chronic obstructive lung disease**years**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> (a) WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) viewed attended the deceased from June 26, 1981 , to October 17, 1984 , that (I) was last saw the deceased alive on October 17, 1984 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) viewed (did not) view the body after death.							
22b. SIGNATURE Thomas G. Sindereson, MD				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED 2-9-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERESON, MD				22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, Md 20862			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/13/1985		23c. NAME OF CEMETERY OR CREMATORY Hyatt's Creek Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Lesterville, Missouri	
24. FUNERAL DIRECTOR NAME Gartner-Sandison Funeral Home				25a. DATE REC'D. BY REGISTRAR FEB 13 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
316 E. Diamond Ave. Gaithersburg, Md. 20760							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, when any injury or other traumatic event, medical or surgical, is indicated, it must be indicated on page 4.

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DR. TAUBER NOTIFIED AND APPROVED

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

05637

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>AUDRIE</u> MIDDLE <u>MARY</u> LAST <u>JACKSON</u> <u>AUDREY MARY JACKSON</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>2</u> <u>11</u> <u>85</u>			2b. HOUR <u>12</u> ¹⁰ <u>P</u> M	
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>5</u> <u>9</u> <u>1903</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>81</u> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>ENGLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.	
10. CITY OR TOWN OF DEATH <u>TAKOMA PARK</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>WASHINGTON ADVENTIST HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		13a. STATE <u>MD.</u>		13b. COUNTY <u>MONT.</u>		13c. CITY OR TOWN <u>SILVER SPRING</u>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>8705 BRADFORD RD. 20901</u>					
14. FATHER'S NAME FIRST MIDDLE LAST <u>WILLIAM</u> <u>FRANKLIN</u> <u>BLAYDES</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ELOISE</u> <u>BAKER</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>579-01-8514D</u>		17. INFORMANT ADDRESS <u>RICHARD E. JACKSON, 416 BRANCH DR. S.S. MD</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Cerebrovascular accident

DUE TO, OR AS A CONSEQUENCE OF

(c)

arteriosclerosisAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1978</u> to <u>2-11</u> <u>85</u> , that (I) (we) lost saw the deceased alive on <u>2-11-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>M. SNOW MD</u>		DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. SNOW, M.D.</u>		22e. ADDRESS <u>9013 Flower Ave S.S. Md 20901</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Feb. 15, 1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Deer Washington Cemetery</u>		23d. LOCATION CITY/TOWN COUNTY STATE <u>Adelphi Md</u>	
24. FUNERAL DIRECTOR NAME <u>Takoma Funeral Home & Undertakers</u>		ADDRESS <u>257 Carroll Rd NW DC</u>		25a. DATE REG. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John F. Rindell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

10

ADOLE

WHITE

PALE

A

12

MONTANA

THAT THE MOUNTAIN RANGE IS NOT WHITE

NO WHITE MOUNTAIN RANGE

SPRING RIVER & JAMES RIVER

THESE ARE THE ONLY MOUNTAIN RANGES IN THE STATE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8505638

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances V. Jackson			2a. DATE OF DEATH MONTH DAY YEAR 2-27-85		2b. HOUR 9:58 P.M.
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Mar. 11 1893		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Takoma Park	
14. FATHER'S NAME FIRST MIDDLE LAST Simeon Hesler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Bailey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Thelma Smith-daughter- (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) Coronary Artery Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the doctor) attended the deceased from Feb. 26, 1985 to Feb. 27, 1985 , that (I) (we) saw the deceased alive on Feb. 27, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thomas J. Codke, M.D.		DEGREE M.D.		22c. DATE SIGNED 2/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas J. Codke, M.D.		22e. ADDRESS 8580 Second Ave. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-2-1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		23e. DATE REC'D BY REGISTRAR MAR 4 1985			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Sil. Spr. Md.		25. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

RODNEY

EUGENE

JACKSON, SR.

2a. DATE KNOWN
OF ESTI
DEATH MATED ☒ MONTH DAY YEAR

2 7 19 85

2b. HOUR

M

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

Feb. 26, 1963

6. AGE (IN YEARS)

21 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

2c. DATE
PRONOUNCED
DEAD

2 7 19 85

2d. HOUR

8A M

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Md.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD.

10. CITY OR TOWN OF DEATH

Gaithersburg

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Goshen Rd. & Snouffers School Rd.

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Cabinetmaker

12b. KIND OF BUSINESS
OR INDUSTRY

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Frederick

13c. CITY OR TOWN

Mt. Airy

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

4317 Molesworth Terrace 21771

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Rudolph S. Jackson

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Eleanor Lancaster

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

220-72-5252

17. INFORMANT

ADDRESS

Eleanor Jackson (Mother) same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Closed head trauma

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 2-7- 19 85

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Driver of auto/fixed object impact.

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

road

21f. LOCATION

Goshen Rd. & Snouffers, Gaithersburg, Mont. Co
School Rd. Md.

22a. I certify that I took charge of the remains described above, held on

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from: Natural causes ☐Accident ☒Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE
SIGNED 2-8-85EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

2-13-85

23c. NAME OF CEMETERY OR CREMATORY

Parklawn Mem. Park

23d. LOCATION

Rockville, Montg. Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

George R. Snowden

246 N. Washington St.
Rockville, Md. 20850

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

FEB 13 1985

10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

Released by Dr. Richard Welton, M.E. 2/11/85 1:00 P.M.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 85 05640			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) STEPHEN (NMI) JACKSON				2b. HOUR 0415 A.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 22, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Yugoslavia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6739 Brigadoon Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President		12b. KIND OF BUSINESS OR INDUSTRY Surgical Sutures	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Misko Jaksekovic				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jana Stefanac			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-46-4647		17. INFORMANT Mr. Janko Jackson, Son, 3323 Wessynton Way, Alexandria, VA. 22309	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0475 MONTHS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 64		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 19 64 to FEBRUARY 13 19 85 , that (I) (we) lost saw the deceased alive on FEBRUARY 13 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jerry Allison Snow, M.D.				DEGREE		22c. DATE SIGNED 2-16-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JERRY ALLISON SNOW, M.D.				22e. ADDRESS 4900 MASSACHUSETTS AVE, NW, D.C. 20016			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE February 19, 1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				25a. DATE REC'D. BY REGISTRAR FEB 21 1985		25b. REGISTRAR'S SIGNATURE [Signature]	
P.A., Bethesda, Maryland							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)
 FIRST MIDDLE LAST
 SAMUEL A. JAFFE

 2a. DATE KNOWN OF DEATH
 ESTIMATED
 MONTH DAY YEAR
 02 08 85
 19
 2b. HOUR
 8:40 AM

1. SEX

M

4. RACE

C

5. DATE OF BIRTH

 MONTH DAY YEAR
 6 19 29

6. AGE (IN YEARS LAST BIRTHDAY)

55 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

 MONTH DAY YEAR
 2 8 85
 19

2d. HOUR

8:40 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

CALIFORNIA

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD

10. CITY OR TOWN OF DEATH

BETHESDA

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

SUBURBAN HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

JOURNALIST

12b. KIND OF BUSINESS OR INDUSTRY

NEWS

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

MONTGOMERY

13c. CITY OR TOWN

BETHESDA

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

6510 BRADLEY BLVD

20817

14. FATHER'S NAME

ABRAHAM

MIDDLE

JAFFE

15. MOTHER'S MAIDEN NAME

DOROTHY

MIDDLE

OYLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

YES

16b. SOCIAL SECURITY NO.

KOREA

16c. SOCIAL SECURITY NO.

552-30-0939

17. INFORMANT

ADDRESS

ELIZABETH JEUNE JAFFE, WIFE, SAME AS #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

CARCINOMA OF THE LUNG

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ACUTE

INDEF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

 UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

 HOUR A.M. MONTH DAY YEAR
 7:30 PM 2 8 85

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

COLLAPSED AT HOME

21d. INJURY OCCURRED

 WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

HOME

21f. LOCATION

 STREET CITY OR TOWN COUNTY STATE
 6510 BRADLEY BLVD CHOCOLY CHASE MONT MD

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☒Inquiry ☒ and in my opinion

death resulted from:

Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

Francis C. Mayle

TITLE (SPECIFY)

DEPT

MEDICAL EXAMINER

DATE SIGNED

2-8-85

EXAMINER'S NAME (TYPE OR PRINT)

FRANCIS C. MAYLE

ADDRESS

8200 WISCONSIN AVE BETHESDA MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

CREMATION

23b. DATE

2/10/85

23c. NAME OF CEMETERY OR CREMATORY

METROPOLITAN CREMATORY

23d. LOCATION

ALEXANDRIA, VIRGINIA

COUNTY

STATE

24. FUNERAL DIRECTOR

RICHARD RAPP, INC.

25a. DATE REC'D. BY REGISTRAR

FEB 13 1985

25b. REGISTRAR'S SIGNATURE

Francis C. Mayle

100-100000-100000

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Verna K. Jansson			2a. DATE OF DEATH MONTH DAY YEAR February 14, 1985		2b. HOUR 4:50P M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 8, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Bureau of Standards
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Gaithersburg		13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 19014 Mills Choice Road / 20879
14. FATHER'S NAME FIRST MIDDLE LAST Edward C. Killian		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Schmieg			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT Norman E. Killian, Brother, 102-05 86th Avenue, Richmond Hills, NY. 11418		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 mos.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1</u> , 19 <u>83</u> , to <u>2/14</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE DEGREE John R. Melnick MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Melnick		22e. ADDRESS 16220 Frederick Rd - Gaithersburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE February 18, 1985	23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR FEB 21 1985		25b. REGISTRAR'S SIGNATURE Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

Handwritten notes and diagrams on lined paper, including a large 'X' and a percentage symbol.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8505643	
1. DECEASED NAME (TYPE OR PRINT) Gregory George Jelly						2a. DATE KNOWN OF DEATH ESTIMATED Feb 4 1985		2b. HOUR 11:30 AM			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH March DAY 22 YEAR 32 YRS.		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD Feb. 2 1985	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.				11. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Sil. Spg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1215 Lockwood Dr. Apt. 1907				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSTALLER		12b. KIND OF BUSINESS OR INDUSTRY C & P	
13a. STATE MD				13b. COUNTY Mont		13c. CITY OR TOWN Sil. Spg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1215 Lockwood Dr. Apt. 1907	
14. FATHER'S NAME FIRST GEORGE MIDDLE H. LAST JELLY						15. MOTHER'S MAIDEN NAME FIRST MARGARET MIDDLE APP LAST APP					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 220-46-7607		17. INFORMANT FATHER ADDRESS 3804 KAYSON ST WHEATON, MD. 20906					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cum hot wound to head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 4 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Shot self					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET Lockwood Dr. CITY OR TOWN Sil. Spg. COUNTY Mont. STATE MD.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D. Dep.				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS				ADDRESS 1919 SEMINARY RD., SILVER SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 2/8/85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY				23d. LOCATION CITY ALEXANDRIA COUNTY VIRGINIA	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR FEB 11 1985		25b. REGISTRAR'S SIGNATURE Davidson-Randall			
24. FUNERAL DIRECTOR ADDRESS 500 UNIV. BLVD, W., SILVER SPRING, MD. 20901											

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U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 05644

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES J. JEROME			2a. DATE OF DEATH MONTH DAY YEAR 2-14-85			2b. HOUR 3:45 PM	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 8, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Budget Analyst		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Cheverly		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Peter - Jarmolowicz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 105-01-3291	
17. INFORMANT Evelyn Jerome		18. ADDRESS 10200 Hatherleigh Dr.		19. CITY OR TOWN Bethesda,		20. STATE Md.	

II. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Multiple myeloma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

MEDICAL CERTIFICATION

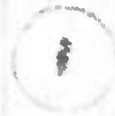
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 19 84 , to FEB 14 19 85 , that (I) (we) last saw the deceased alive on FEB 14 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Pamela Mulsane		22c. DATE SIGNED 2/14/85				22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAMELA MULSANE	
22e. ADDRESS 10500 SUMMITT KENSINGTON		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb/15/85		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G. Co., Maryland	
24. FUNERAL DIRECTOR NAME Chambers Funeral Home		ADDRESS Riverdale, Maryland		25a. DATE REC'D. BY REGISTRAR FEB 1 9 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, there is any injury, or other traumatic event, the medical examiner must be notified of such.



Handwritten notes and stamps in the top left corner, including a rectangular stamp with illegible text.

Handwritten text in the top center, possibly a date or reference number.

Handwritten text in the top right corner.

Handwritten text in the middle left section.

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Handwritten text in the middle right section.

Handwritten text spanning the width of the page in the lower middle section.

Handwritten text in the lower middle left section.

Handwritten text in the lower middle right section.

Handwritten text in the bottom left section.

Handwritten text in the bottom center section.

Handwritten text in the bottom right section.

Handwritten text in the bottom left section, possibly a date.

Handwritten text in the bottom right section.

Handwritten text in the bottom center section.

Handwritten text in the bottom center section.

X

Handwritten text in the lower section, possibly a signature or large note.

Large handwritten text in the bottom section, possibly a signature or large note.

Handwritten text in the bottom left section.

Handwritten text in the bottom right section.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen E. Johnson						2a. DATE OF DEATH MONTH DAY YEAR 2/23/85			2b. HOUR 1003M		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 12, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR WAR MEMORIALS		12b. KIND OF BUSINESS OR INDUSTRY D.O.D.			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1988 MILBORO DRIVE 20854			
14. FATHER'S NAME FIRST MIDDLE LAST HARRY E. BURCH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LOUISE TENNYSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-32-8249		17. INFORMANT ADDRESS ELIZABETH J. CULLINANE DAUGHTER SAME AS 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: PULMONARY EDEMA											
19a. DATE OF OPERATION 2-23-85				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 2-23 , 19 85 , that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John E. Kelly				DEGREE For Dr. P. Moore				22c. DATE SIGNED 2-23-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Kelly				22e. ADDRESS 9715 Medical Center Dr. no 20854 Rockville							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 27, 1985		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PR. GEO. MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR MAR 1 1985				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			
500 UNIVERSITY BOULEVARD, W. SILVER SPRING, MD.											

BP _____

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11-2-10

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11/10/11

[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side. The text is mostly mirrored and difficult to decipher.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

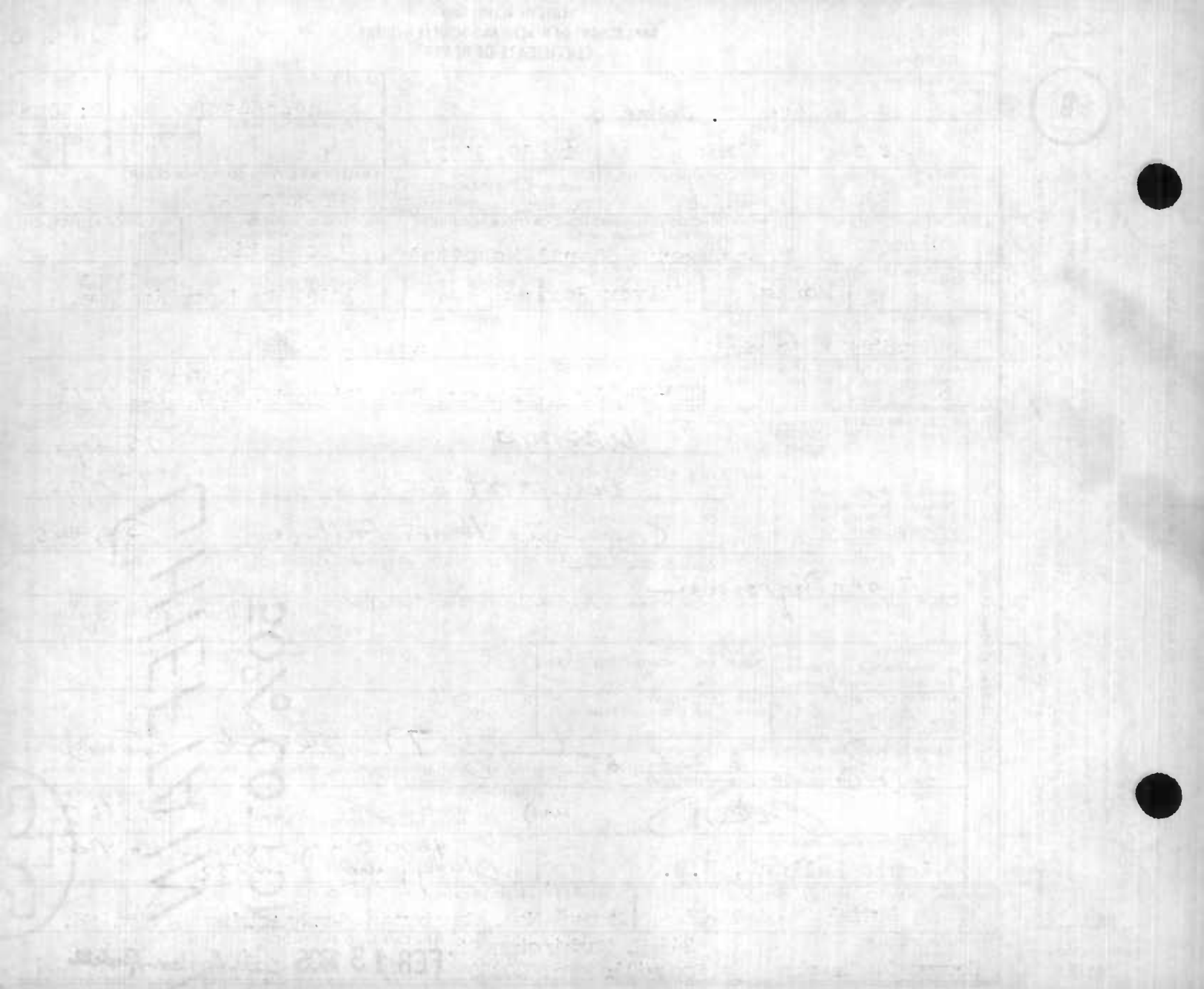
1- FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE	
Henrietta M. Johnson		Female		Black	
5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
May 19, 1898		86 YRS.		Md.	
7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
U.S.A.				MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Olney		Montgomery General Hospital		Domestic	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		Montg.		Silver Spring	
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>	
Isaiah F. Marshall		Rebecca Johnson		13e. STREET ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-30-2655		P.O. Box 38 Eleanora Hood (Sister) Ashton, Md. 20861	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
UREMIA		15 days			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Dehydration		17 days	
(c) Congestive Heart Failure				5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21e. LOCATION CITY OR TOWN COUNTY STATE	
21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21g. LOCATION STREET		21h. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from saw the deceased alive on 6 Feb 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)		22b. SIGNATURE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
Lewis Kellert, M.D.		4000 Olney Laytonville Rd, Olney, Md. 20832		22g. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2-23-85		Mutual Mem. Cemetery	
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. LOCATION CITY OR TOWN COUNTY STATE	
George R. Snowden		246 N. Washington St. Rockville, Md. 20850		Sandy Spring, Montg. Md.	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



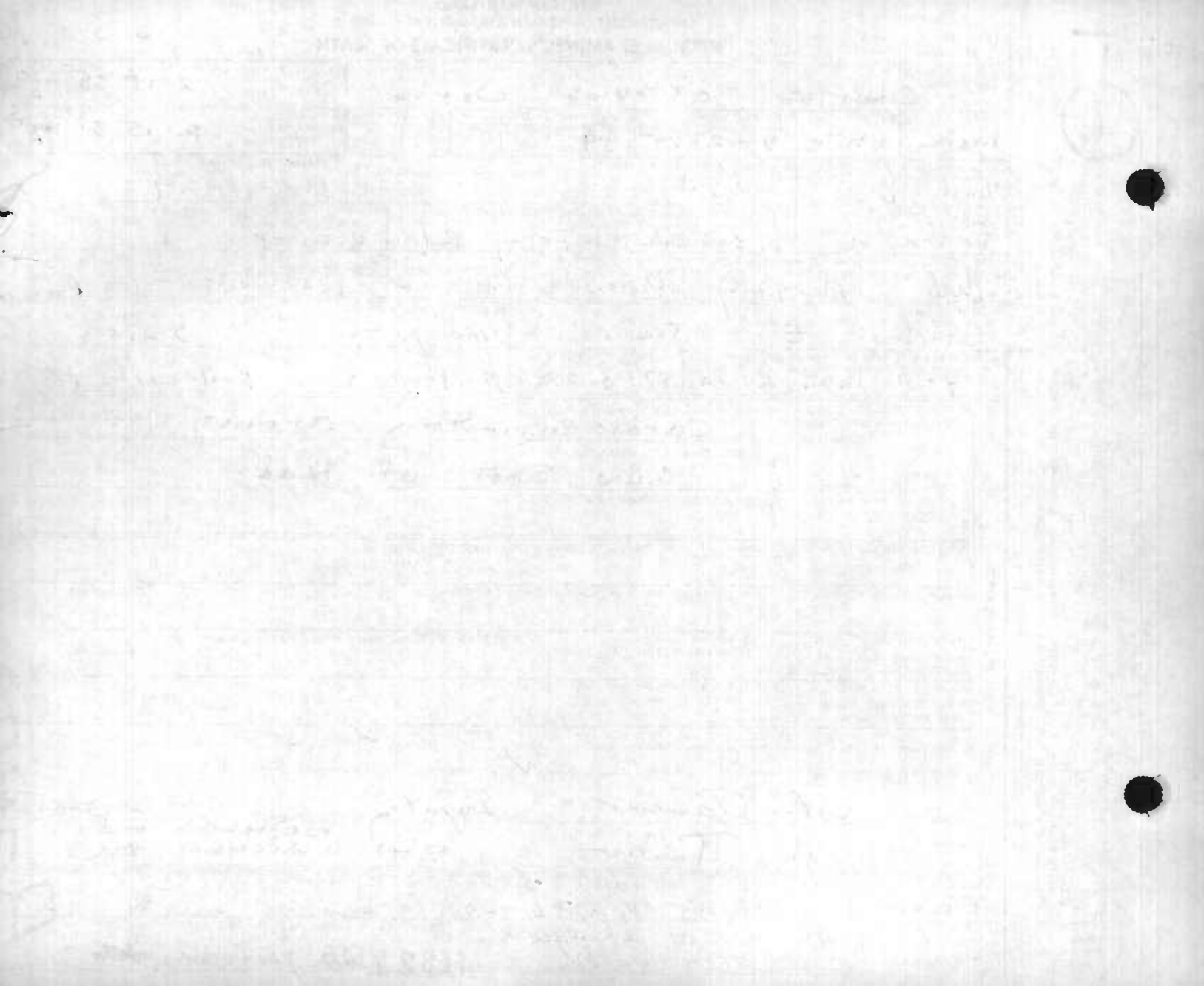


BP
DHMH: 17
(VR A15 ME (5))
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE. TO EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 05647	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Charles Octavius Jones										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 2 DAY 15 YEAR 85 2b. HOUR 2:20 A <input checked="" type="checkbox"/> M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 8 DAY 2 YEAR 25		6. AGE (IN YEARS) LAST BIRTHDAY 59 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH 2 DAY 15 YEAR 85 2d. HOUR 2:20 A <input checked="" type="checkbox"/> M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash DC.				7b. CITIZEN OF WHAT COUNTRY? USA.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Poolesville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 17800 Whites Ferry Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.				13b. COUNTY Montgomery		13c. CITY OR TOWN Poolesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 17800 Whites Ferry Rd.	
14. FATHER'S NAME FIRST Charles MIDDLE E. LAST Jones				15. MOTHER'S MAIDEN NAME FIRST Marguerite MIDDLE Simons LAST Simons							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 577-302540		17. INFORMANT Mrs. Phyllis Jones				ADDRESS Poolesville Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Gun Shot of Head. (b) Gun Shot of Head. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Tamber				TITLE (SPECIFY) Deputy				DATE SIGNED 2-15-85			
EXAMINER'S NAME (TYPE OR PRINT) John Tamber				ADDRESS 8216 Wisconsin Ave							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 2/16/1985		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN				23d. LOCATION CITY OR TOWN ARLINGTON COUNTY ARLINGTON STATE VA	
24. FUNERAL DIRECTOR NAME W.C. HILTON				ADDRESS 22111 BEAULIEVILLE RD.				25a. DATE REC'D. BY REGISTRAR FEB 27 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8505648

1. FOR STATE REGISTRAR			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Jeanne E. Justement			2a. DATE OF DEATH MONTH DAY YEAR February 19, 1985		
3. SEX Female			2b. HOUR 10:40 pm		
4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Mar. 22, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France		7b. CITIZEN OF WHAT COUNTRY? United States		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Maryland		13b. COUNTY Montgomery		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
14. FATHER'S NAME FIRST MIDDLE LAST Not Available		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available		13c. STREET ADDRESS 20879 10415 Kardwright Court	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-46-5473		17. INFORMANT Marguerite J. Schreiber, same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Congestive Heart Failure Hypertensive Heart Dis. Atherosclerosis PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b):					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days Years "
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
22. I certify that (i) (this hospital) attended the deceased from 2/12/85 to 2/20/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we told) (did not view the body after death)					
22a. SIGNATURE [Signature]		22b. DEGREE MD		22c. DATE SIGNED 2/20/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John J. [Signature]		22e. ADDRESS 616 Robinson Rd, Bethesda		22f. CITY OR TOWN Rockville	
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE Feb. 22, 1985		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park	
23d. LOCATION (CITY OR TOWN) Rockville		23e. COUNTY Maryland		23f. STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphyrey Funeral Homes, P.A. Rockville, Maryland 20850		25a. DATE REC'D. BY REGISTRAR FEB 28 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8505649

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George H. Kahn			2a. DATE OF DEATH MONTH DAY YEAR February 22, 1985		2b. HOUR 4:27pm
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan. 15, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County Maryland MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer	12b. KIND OF BUSINESS OR INDUSTRY Printing	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Robert Kahn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Willmore		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW I		16b. SOCIAL SECURITY NO. 577 10 8794	17. INFORMANT Daughter Juanita P. Nicholson Same as item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia Chronic lung disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 days 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 85 to 22 Feb 85, that (I) (we) last saw the deceased alive on 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael Leibowitz		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 22 Feb 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibowitz, M.D.		22e. ADDRESS 11120 New Hampshire Ave. S.S. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 25, 1985	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND		25a. DATE REC'D. BY REGISTRAR FEB 28 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.)

MEDICAL CERTIFICATION

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Nathaniel Kalman</i>			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>Feb. 22 1985</i>			2b. HOUR <i>5 AM</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 18, 1916</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>68 YRS.</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>Feb 22 1985</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery, MD</i>		
10. CITY OR TOWN OF DEATH <i>S. S. Spg.</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>U.S. Gov't. Engineer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>V. A. Admin.</i>
13a. STATE <i>MD</i>			13b. CITY OR TOWN <i>Mont. S. Spg.</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS <i>1011 Loxford Terr.</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Kalman Kalmanowitz</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Pauline Trager</i>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes WWII</i>		
17. SOCIAL SECURITY NO. <i>059-05-1548</i>			18. INFORMANT ADDRESS <i>Md. 20901</i> <i>Dorothy Kalman; 1011 Loxford Terrace; S. Spg.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Inf.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>None</i>								
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) M.D. <i>Dip.</i>			MEDICAL EXAMINER DATE SIGNED <i>Feb. 20 1985</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS, M.D.</i>			ADDRESS <i>1919 Seminary Road; Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/22/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Adelphi; P.G.; Maryland</i>		
24. FUNERAL DIRECTOR <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i> <i>1170 Rockville Pike; Rockville, Md. 20852</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 26 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BEATRICE S. KALSTEIN			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 11 85		2b. HOUR A M 9:36 A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 31, 1917		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Beloff		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Wenig		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 183-16-0123-D		17. INFORMANT ADDRESS Hannah Kalstein (Same as # 13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation with cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal failure						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		70a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 19 84 , to February 11, 19 85 , that (I) was did saw the deceased alive on February 10, 19 85 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did (did not) view the body after death.						
22b. SIGNATURE Byrl D. Johnson		DEGREE M.D.		22c. DATE SIGNED 2/12/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Byrl D. Johnson, M. D.		22e. ADDRESS 16220 Frederick Road, Gaithersburg, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/14/1985		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		
23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia		25a. DATE REC'D. BY REGISTRAR FEB 1 9 1985				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 05652	
1. DECEASED NAME (TYPE OR PRINT) Andrew Craig Kaplan						2a. DATE KNOWN OF DEATH ESTIMATED 2 13 85		2b. HOUR 10:30		2c. MONTH 19	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH 4 DAY 15 YEAR 71		6. AGE (IN YEARS LAST BIRTHDAY) 13 YRS.		7. IF UNDER 1 YR. MONTHS 0 DAYS 0		7. IF UNDER 24 HRS. HOURS 0 MIN 0	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Potomac				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10101 Ormond Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Harvey MIDDLE Kaplan LAST Kaplan						15. MOTHER'S MAIDEN NAME FIRST Sharon MIDDLE Libava LAST Libava					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216-80-1771		17. INFORMANT ADDRESS 20854 Harvey Kaplan; 10101 Ormond Road; Potomac, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) asphyxiation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost, hanging (b) hanging DUE TO, OR AS A CONSEQUENCE OF (c) hanging										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John Tauber				TITLE (SPECIFY) Deputy				DATE SIGNED 2-14-85			
EXAMINER'S NAME (TYPE OR PRINT) John Tauber				ADDRESS 8218 Wisconsin Ave							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/15/85		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN				23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH; FAIRFAX: VA.	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS						25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez			
1170 Rockville Pike; Rockville, Maryland 20852											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 05653	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) EDWIN VICTOR KAPP										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 2 DAY 28 YEAR 1985	
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH Feb. DAY 4 YEAR 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD MONTH MARCH DAY 1 YEAR 1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH GAITHERSBURG			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 517-D SO. FREDERICK AVE. # 101				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			12b. KIND OF BUSINESS OR INDUSTRY Electronic	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 20860 XX 517-D So. FREDERICK AVE. #10			
14. FATHER'S NAME FIRST Victor MIDDLE Randolph LAST Kapp						15. MOTHER'S MAIDEN NAME FIRST Ruth MIDDLE Mason LAST Mason					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW 11 212-03-3324		17. INFORMANT ADDRESS 1707 Glen Ridge Road Baltimore, Maryland Mrs. Nancy W. Condit - Daughter 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Tauber				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED March 2, 1985			
EXAMINER'S NAME (TYPE OR PRINT) JOHN F. TAUBER, MD.				ADDRESS 8218 WISCONSIN AVENUE BETH., MD. 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE MARCH 3, 1985		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA		
24. FUNERAL DIRECTOR FRANCIS J. COLLINS FUNERAL HOME, INC. S.S., Md.						25a. DATE RECEIVED BY REGISTRAR MAR 7 1985		25b. REGISTRAR'S SIGNATURE Gene Davidson-Randall			



State of Maryland
 Department of Transportation
 2200 North Washington Avenue
 Baltimore, Maryland 21201
 March 1, 1982

To: Mr. J. Edgar Hoover
 Federal Bureau of Investigation
 Department of Justice
 Washington, D.C. 20535
 From: Mr. [Name obscured]
 Director, Maryland Department of Transportation
 Subject: [Subject obscured]
 Reference: [Reference obscured]

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.
 Very truly yours,
 [Signature]
 Director, Maryland Department of Transportation
 March 1, 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

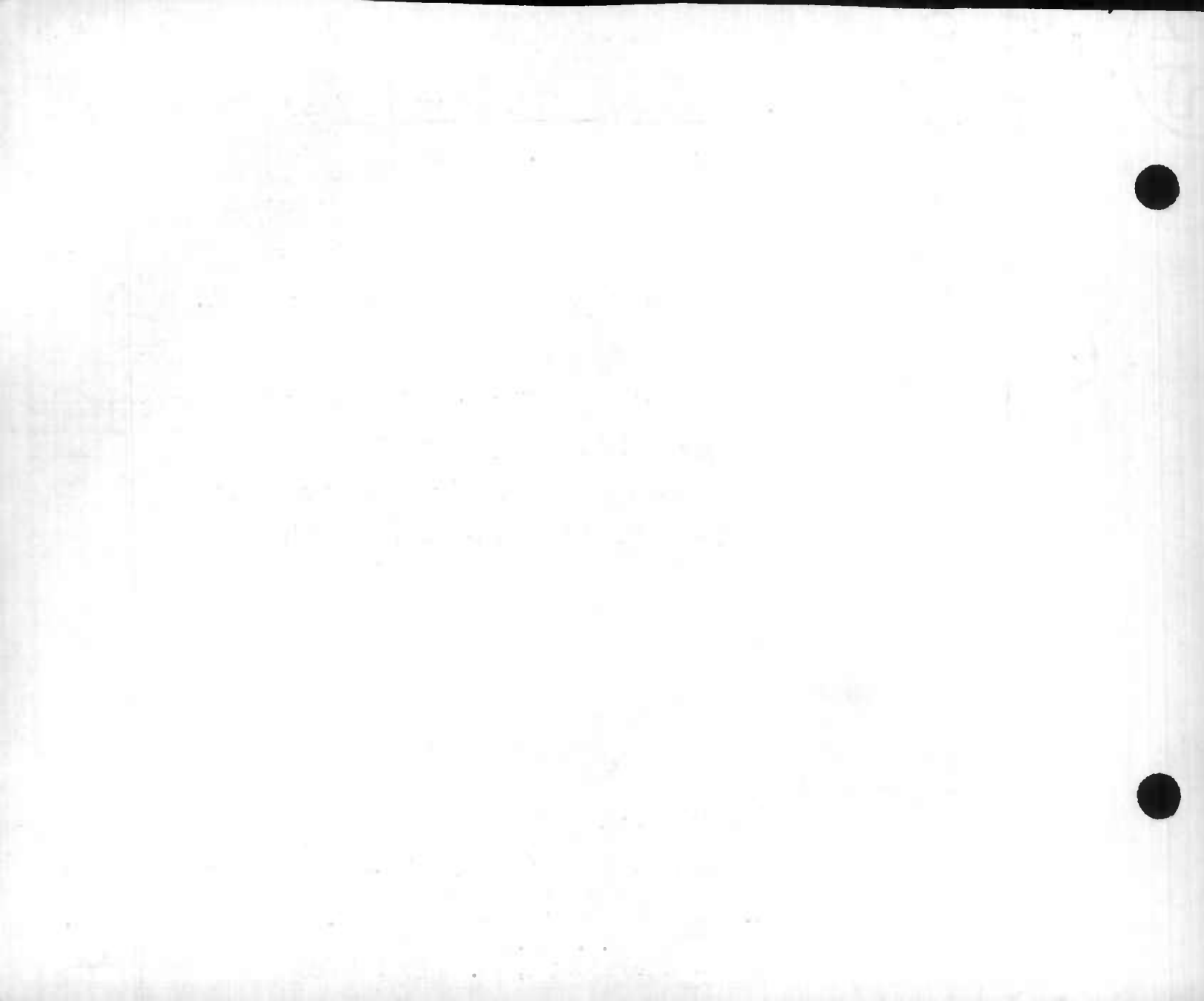
8 5 0 5 6 5 4

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARA T. KEARNS-PRESTON			2a. DATE OF DEATH MONTH DAY YEAR 2/15/ 1985			2b. HOUR 1:25 A.M.					
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan. 18 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14603 Edelman Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professor		12b. KIND OF BUSINESS OR INDUSTRY Mitchell College			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14603 Edelman Dr. 20906		
14. FATHER'S NAME FIRST MIDDLE LAST William Thompson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Frick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Davis A. Kearns-Preston-husband-(same as 13e)		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia - Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lupus - Hypertension</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>January 19 85</u> to <u>Feb/14</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Hamid Montakhab</u>					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/15/1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAMID MONTAKHAB					22e. ADDRESS 611 Executive Bldg, Rockville MD 20852						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 18, 1985		23c. NAME OF CEMETERY OR CREMATORY Grace Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Jackson Va.				
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home Silver Spring, Md.					25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>				

BP



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) SARAH MAY KELLER						2a. DATE OF DEATH MONTH 1 DAY 28 YEAR 85		2b. HOUR 12²⁵ P M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH Dec. DAY 6, YEAR 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 24 HRS HOURS MIN. 				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.								
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sewing machine Operator		12b. KIND OF BUSINESS OR INDUSTRY clothing						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 78 Mellor Avenue 20850						
14. FATHER'S NAME FIRST Frank MIDDLE LAST Keller					15. MOTHER'S MAIDEN NAME FIRST Catherine MIDDLE LAST Dontell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 316-01-6293A		17. INFORMANT ADDRESS Rev. Richard Reichard 9701 Veirs Dr. Rockville, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease										5 yrs				
DUE TO, OR AS A CONSEQUENCE OF (c) 														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 														
19a. DATE OF OPERATION 				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>Nov. 12</u> , 19 <u>69</u> , to <u>Jan. 28</u> , 19 <u>85</u> , that (I) <u>we</u> last saw the deceased alive on <u>Jan. 18</u> , 19 <u>85</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> <u>did</u> (did not) view the body after death.														
22b. SIGNATURE Harold F. McCann, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-29-85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD F. MCCANN				22e. ADDRESS 3355 16th St N.W. WASH. D.C. 20010										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Jan. 31, 1985		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery				23d. LOCATION CITY OR TOWN Baltimore, COUNTY Maryland STATE 						
24. FUNERAL DIRECTOR The Hysong Co. 1300 N St. N.W. Washington, D.C.				25a. DATE REC'D. BY REGISTRAR FEB 13 1985				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell						

BP

11-11-1902

Dec. 9, 1902

Wm.

James

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England

Western, Eastern

Western

75 No. 1st Avenue

X

Belgium, France

Belgium

France

Belgium

Belgium

Belgium

11-1-1902 Rev. John H. ...

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Belgium

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Central ... 11-1-1902 ...

The ... Co. 11-1-1902 ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 05656

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Evelyn Mary Kelley</i>			2a. DATE OF DEATH MONTH <i>Feb.</i> DAY <i>23</i> YEAR <i>1985</i>		2b. HOUR <i>1:30 P.M.</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>4</i> DAY <i>30</i> YEAR <i>1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i>	7. UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>
7a. BIRTH PLACE (STATE OR FOREIGN) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD	
8. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OR WORK OR MOST RECENT WORK) <i>Sales Clerk (Retired)</i>	
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Tekoma Pk.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>7620 Maple Ave. Tekoma Park, MD 20913</i>	
14. FATHER'S NAME FIRST <i>Isaac</i> MIDDLE <i>M.</i> LAST <i>Manuel</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Jessie</i> MIDDLE <i>Jackson</i> LAST <i>Walter</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>217-30-0996</i>		17. INFORMANT NAME <i>Theresa Lee Davis</i> ADDRESS <i>1709 Keyway N Silver Spring</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Stroke*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

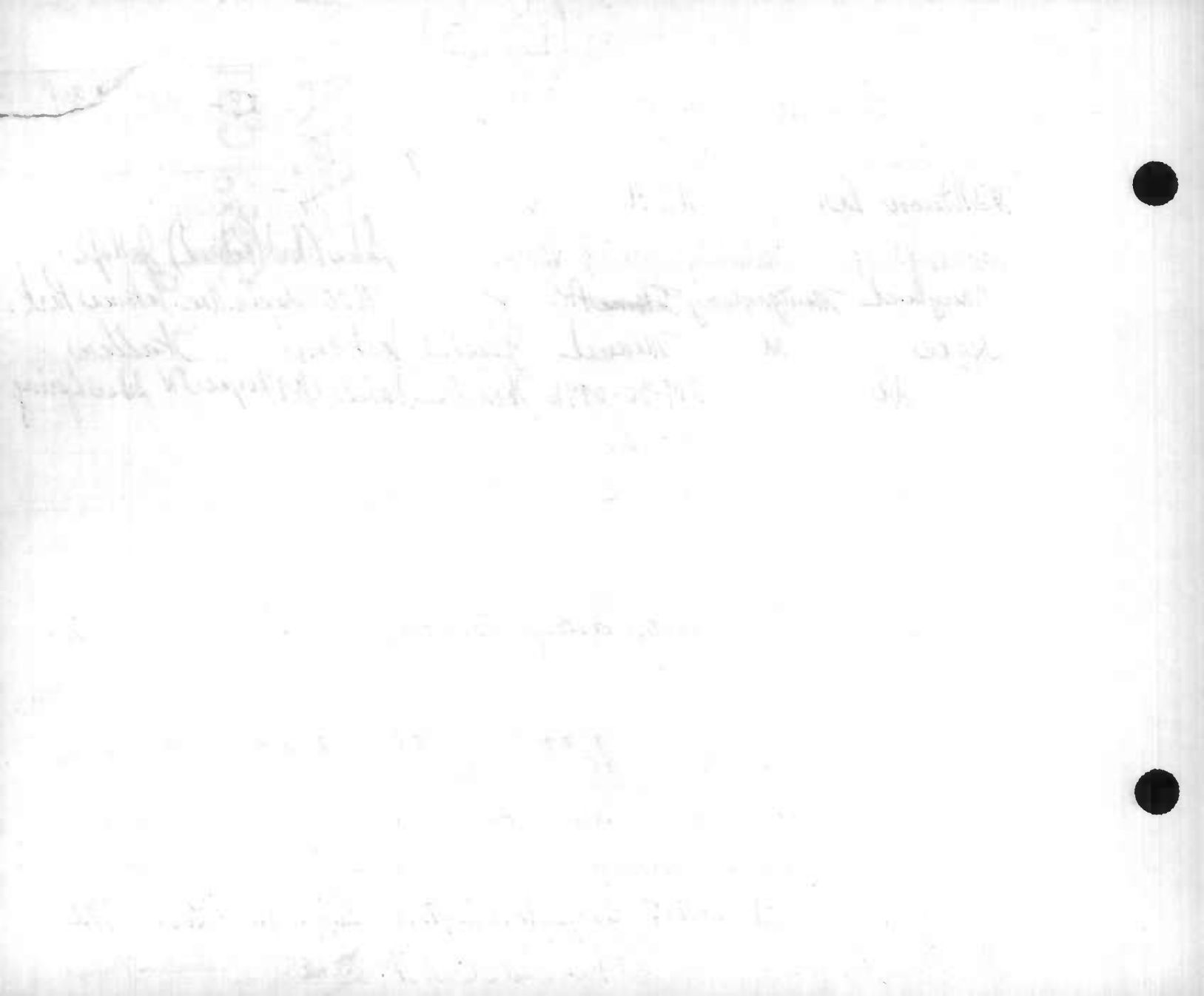
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <i>1.28.85</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carotid artery stenosis</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1.27</i> , 19 <i>85</i> , to <i>2.23</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>2.23</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Rajindra K. Sarin</i>		22c. DATE SIGNED <i>2/23/85</i>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RAJINDRA K. SARIN</i>		22c. ADDRESS <i>6201 G. Embell Rd College Pk Md</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>Feb. 26 - 1985</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Knights of the Ku Klux Klan</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>College Pk. Md.</i>
24. FUNERAL DIRECTOR <i>Walter W. Walters</i>		25. DATE RECEIVED BY REGISTRAR <i>FEB. 28 1985</i>	
26. REGISTRAR'S SIGNATURE <i>Walter W. Walters</i>		27. REGISTRAR'S SIGNATURE <i>Walter W. Walters</i>	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
FIRST MIDDLE LAST William H. KENT		2-25-85		4 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MALE	WHITE	MONTH DAY YEAR NOV. 10, 1894	90 YRS.	MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		Montgomery County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Gaithersburg	Wilson Health Care Center	CAB DRIVER	TAXI		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS		
13a. STATE COUNTY MARYLAND MONTGOMERY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	201 RUSSELL AVENUE / 20878		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST GEORGE - KENT		FIRST MIDDLE LAST CARRIE - (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
YES <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) WWI		213-05-7672	HOWARD KENT (SON) RD 3 BOX 25 OWEGO, N.Y. 13827		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Acute Respiratory Distress -					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema -					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Chronic obstructive pulmonary disease -					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: -					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (we) attended the deceased from above, (II) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Thos. G. WARD				2/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Thos. G. WARD		6116 Robinson Blvd., 20817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
CREMATION	FEB. 25, 1985	CHAMBERS CREMATORY		RIVERDALE P.G. CO. MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
CHAMBERS FUNERAL HOME SILVER SPRING, MD.		MAR 1 1985		Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

BP

acute respiratory distress -
 Complications -
 pleural effusion, pulmonary

that

2/22

2/19/83

1/22/83

X

X

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Kenneth S. Kesecker			2a. DATE OF DEATH MONTH DAY YEAR February 10, 1985			2b. HOUR 3:15A_M			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 19, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9411 Rosehill Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9411 Rosehill Drive/20817	
14. FATHER'S NAME FIRST MIDDLE LAST James H. Kesecker					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lafayette Hobdy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-01-3315		17 INFORMANT ADDRESS Helen P. Kesecker, same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory insufficiency								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one week	
DUE TO, OR AS A CONSEQUENCE OF (b) metastatic epidermoid carcinoma of lung								18 mo	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this Hospital) attended the deceased from April 1 19 83 , to Feb 10 19 85 , that (I) (we) last saw the deceased alive on 1/24 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE G. Peter Pushkas MD								22c. DATE SIGNED 2/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Peter Pushkas						22e. ADDRESS 11510 Old Georgetown Rd. Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial		23b. DATE Feb. 13,		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood,		23d. LOCATION CITY OR TOWN COUNTY STATE Maryland			
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						25a. DATE RECD. BY REGISTRAR FEB 14 1985		25b. REGISTRAR'S SIGNATURE Wenderson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

INVESTIGATOR: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



WEEKLY BOUND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUSSELL GARRY KETTERMAN					2a. DATE OF DEATH MONTH DAY YEAR 2 15 85				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH AUG. 27, 1909 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7b. HOUR 09²⁸ M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY SHEET METAL	
13a. STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 113 Central Ave. 20877	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Wesley Ketterman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret - Ours				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -UNK.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Amae J. Ketterman		ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiophem - arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 12/15/85 3 1/2 hrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Anoxic encephalopathy									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 1125		CITY OR TOWN 15		COUNTY 19 85	
22a. I certify that (I) (this hospital) attended the deceased from 11/25/85 , 19 85 , to 2/15 , 19 85 , that (I) (we) last saw the deceased alive on 2/14 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dennis Friseman				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S ADDRESS (TYPE OR PRINT) Dennis Friseman				22e. ADDRESS 13-15 E Deer Park Dr Gaithersburg					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 18, 1985		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION CITY OR TOWN Gaithersburg		COUNTY Mont.	
24. FUNERAL DIRECTOR FRANCIS H. BARBER		LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR FEB 20 1985		25b. REGISTRAR'S SIGNATURE John K. ...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

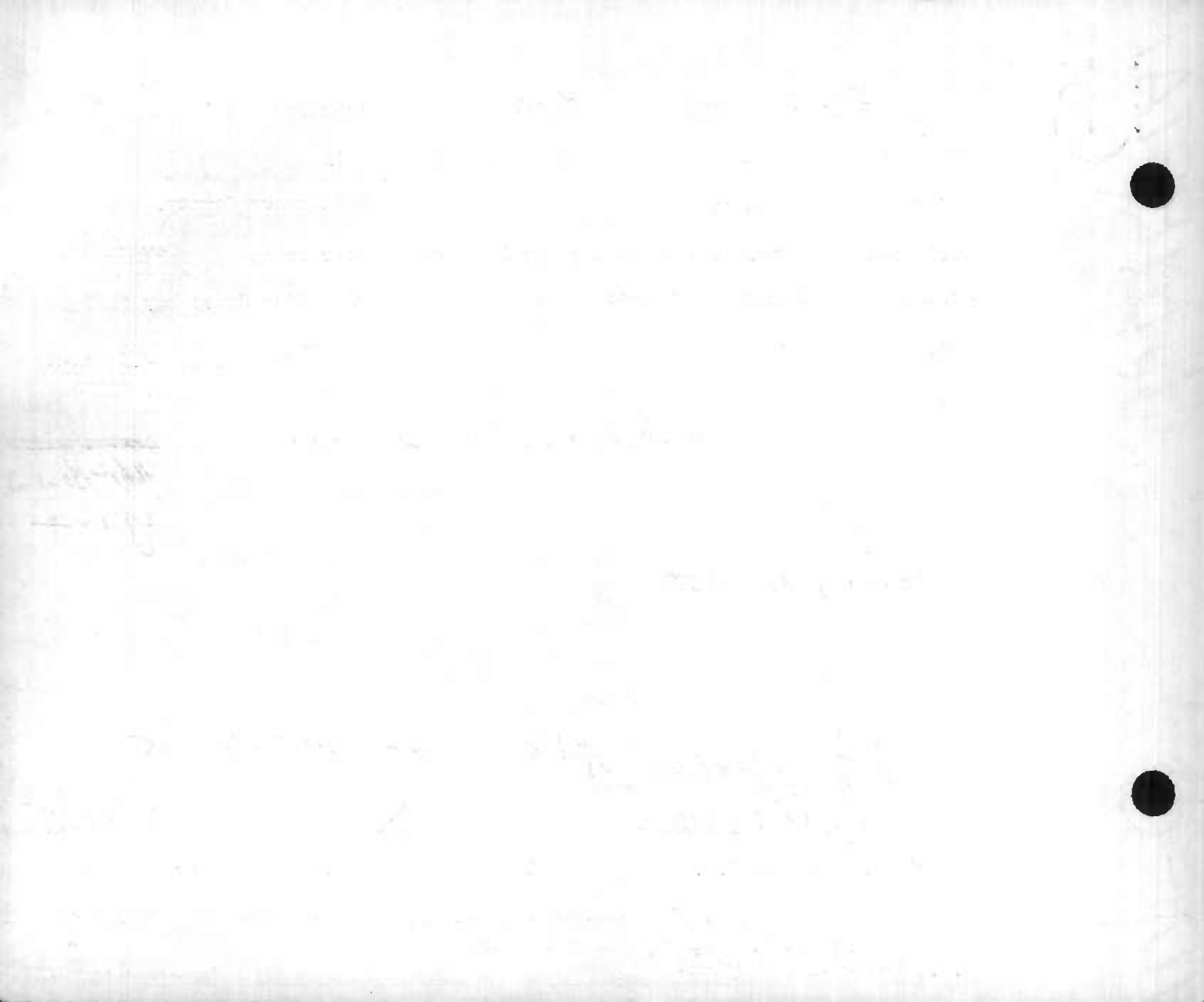
IMPORTANT: If item 21 is marked or initialed as such, any injury or other traumatic event, the medical examiner must be notified of this.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Eui Joon Kim			2a. DATE OF DEATH MONTH DAY YEAR February 14, 1985		2b. HOUR 4:00A M
3 SEX Male	4 RACE Korean	5. DATE OF BIRTH MONTH DAY YEAR April 28, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea	7b. CITIZEN OF WHAT COUNTRY? Korea	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Congressman		12b. KIND OF BUSINESS OR INDUSTRY Korean Government
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Kwang Woon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Soon Young Lee		13e. STREET ADDRESS / ZIP CODE 17060 King James Way #107 20877	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220 94 9725		17. INFORMANT 11908 ^S Henry Fleet Drive Eui Young Kim Son Potomac, Md. 20854	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>coma, decubiti</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several days</u> <u>several years</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>3-18</u> 19 <u>84</u> to <u>14 Feb</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1/24/</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <u>David B. Kessler</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/14/85</u>	
22d. PHYSICIAN'S NAME (TYPE COMPLETELY) David B. Kessler, M.D.		22e. ADDRESS 10620 Georgia Ave. Silver Spring, Md 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS P.A., Rockville, Maryland			
25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
1. SEX				4. RACE				5. DATE OF BIRTH			
7a. BIRTHPLACE (COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN			
14. FATHER'S NAME FIRST LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anemia</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Anemia</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the deceased) attended the deceased from <u>8-28-81</u> , 19 <u>81</u> , to <u>2-2-</u> 19 <u>85</u> , that (I) (we) saw the deceased alive on <u>2-2-85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>George B Patrick Jr MD</u>				DEGREE				22c. DATE SIGNED <u>2-2-85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George B. Patrick, Jr MD</u>				22e. ADDRESS <u>9221 Colesville Rd. Silver Spring, Md 20910</u>				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				23b. DATE <u>2/5/85</u>				23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>			
23d. LOCATION CITY OR TOWN <u>SILVER SPRING</u>				COUNTY <u>MONT</u>				STATE <u>MD.</u>			
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u>				25. DATE REC'D. BY REGISTRAR <u>FEB 7 1985</u>				25b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>			
500 UNIV BLVD. W. SILVER SPRING, MD. 20901											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

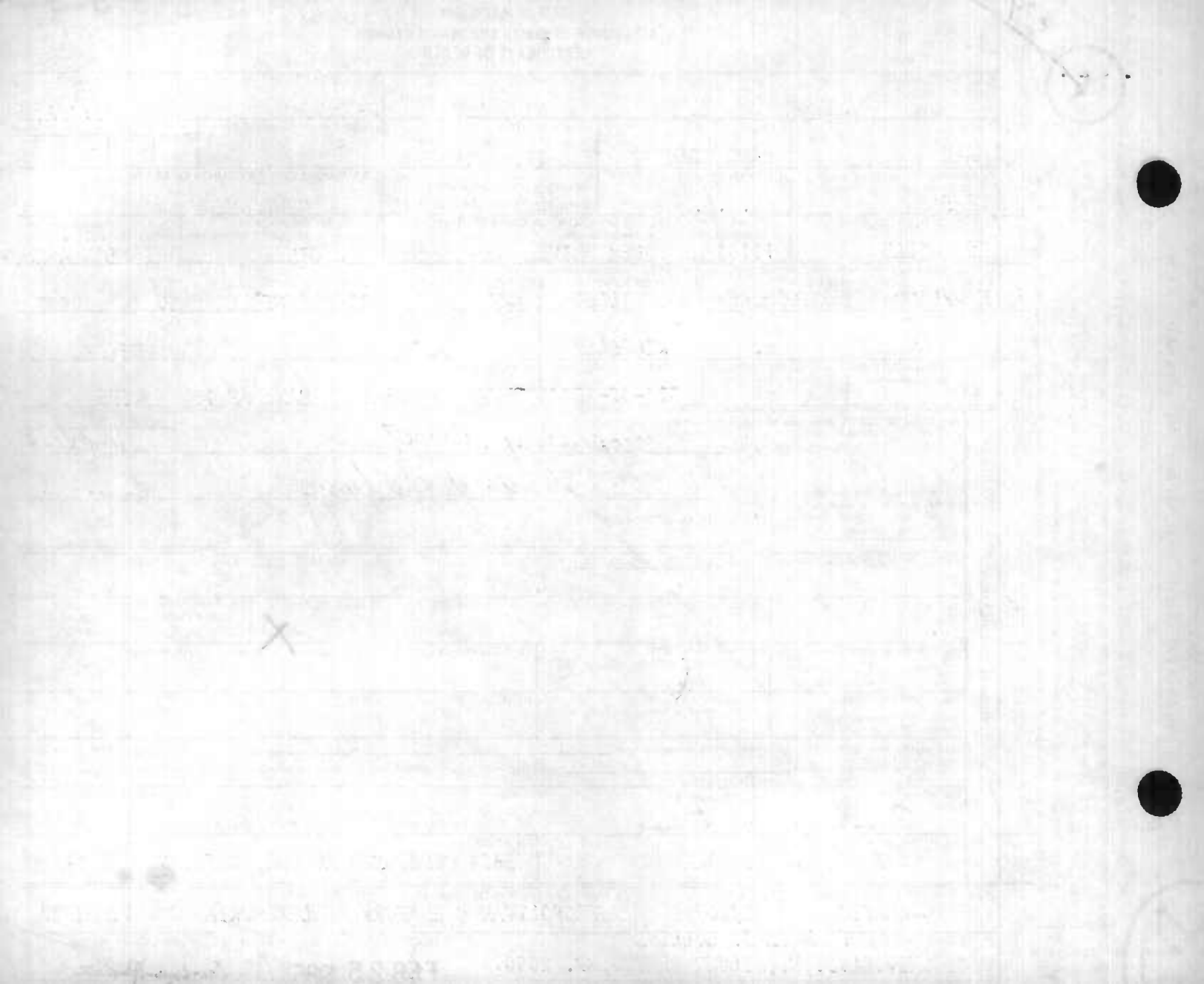
FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ARTHUR KEITH KINGSLEY			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 20, 1985			2b. HOUR 8:40A, M				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR FEB 17, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KANSAS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11100 HUNTOVER DRIVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY AVIATION AGENCY		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11100 HUNTOVER DRIVE 20852	
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR R. KINGSLEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA BETTS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO Yes 1944-58			16b. SOCIAL SECURITY NO. 515-07-6584		17. INFORMANT Elizabeth M. Kingsley BETTY KINGSLEY SAME AS 13 WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 yrs -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>none flat</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Frederick A. Barr</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/20/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK A. BARR						22e. ADDRESS 5454 WISCONSIN AVENUE, BETHESDA, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 2/20/85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY			23d. LOCATION CITY OR TOWN COUNTY ALEXANDRIA VIRGINIA		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR FEB 25 1985		25b. REGISTRAR'S SIGNATURE <u>Frederick A. Barr</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. FOR #16, Film G603 5/13/85									
1. DECEASED NAME (TYPE OR PRINT) L. Donald KITTLE					2a. DATE OF DEATH MONTH 2 DAY 5 YEAR 85 2b. HOUR 410 P.M.				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH 11 DAY 19 YEAR 38		6. AGE (IN YEARS LAST BIRTHDAY) 46		IF UNDER 1 YEAR MONTHS YRS DAYS HRS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adv. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wood-worker		12b. KIND OF BUSINESS OR INDUSTRY Furniture	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11521 Idlewood Road/ 20906		
14. FATHER'S NAME FIRST Paul MIDDLE A. LAST Kittle					15. MOTHER'S MAIDEN NAME FIRST R. MIDDLE Mildred LAST Kessling				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 234 58 6622		17. INFORMANT ADDRESS Linda A. Kittle, wife, see #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ESOPHAGEAL CANCER								4 MONTHS	
DUE TO, OR AS A CONSEQUENCE OF (c) ESOPHAGEAL ADENOCARCINOMA								4 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) PLEURAL EFFUSIONS, GASTRIC OBSTRUCTION									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/21 19 85 to 2/5 19 85 , that (I) (we) last saw the deceased alive on 2/5 19 85 , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Mark Birns				DEGREE MD				22c. DATE SIGNED 2/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK BIRNS, MD				22e. ADDRESS 9715 MEDICAL CT RD #200 ROCKVILLE, MD 20850					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 9, 1985		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park			23d. LOCATION CITY OR TOWN Rockville, COUNTY Maryland STATE		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, ADDRESS P.A. Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR FEB 8 1985		25b. REGISTRAR'S SIGNATURE John A. Anderson			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bernice B. Klein			2a. DATE OF DEATH MONTH DAY YEAR 2 25-85			2b. HOUR 1 4 M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 15 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. POST OFFICE		12b. KIND OF BUSINESS OR INDUSTRY	

13a. STATE MD			13b. COUNTY MONT.		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7057 CARROLL AVE 20912	
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14. FATHER'S NAME FIRST MIDDLE LAST BROOKS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH		
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS JAMES M. FOREMAN - 6704 CURTINA DR. HIGHLAND MD	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH <u>> 1 Year.</u>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 1/13, 1985, to 2/25, 1985, that (II) (we) lost the deceased alive on 2/24/85, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)

22b. SIGNATURE David Cromwell MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID CROMWELL		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MARCH 1, 1985		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION Brentwood COUNTY MD	
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24. FUNERAL DIRECTOR NAME Takoma Funeral Home J. J. Walter		ADDRESS 251 Carroll Creek Dr. DC		25a. DATE REC'D. BY REGISTRAR FEB 28 1985		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then only injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for

#1, percall w/FH 2/27/85 kam

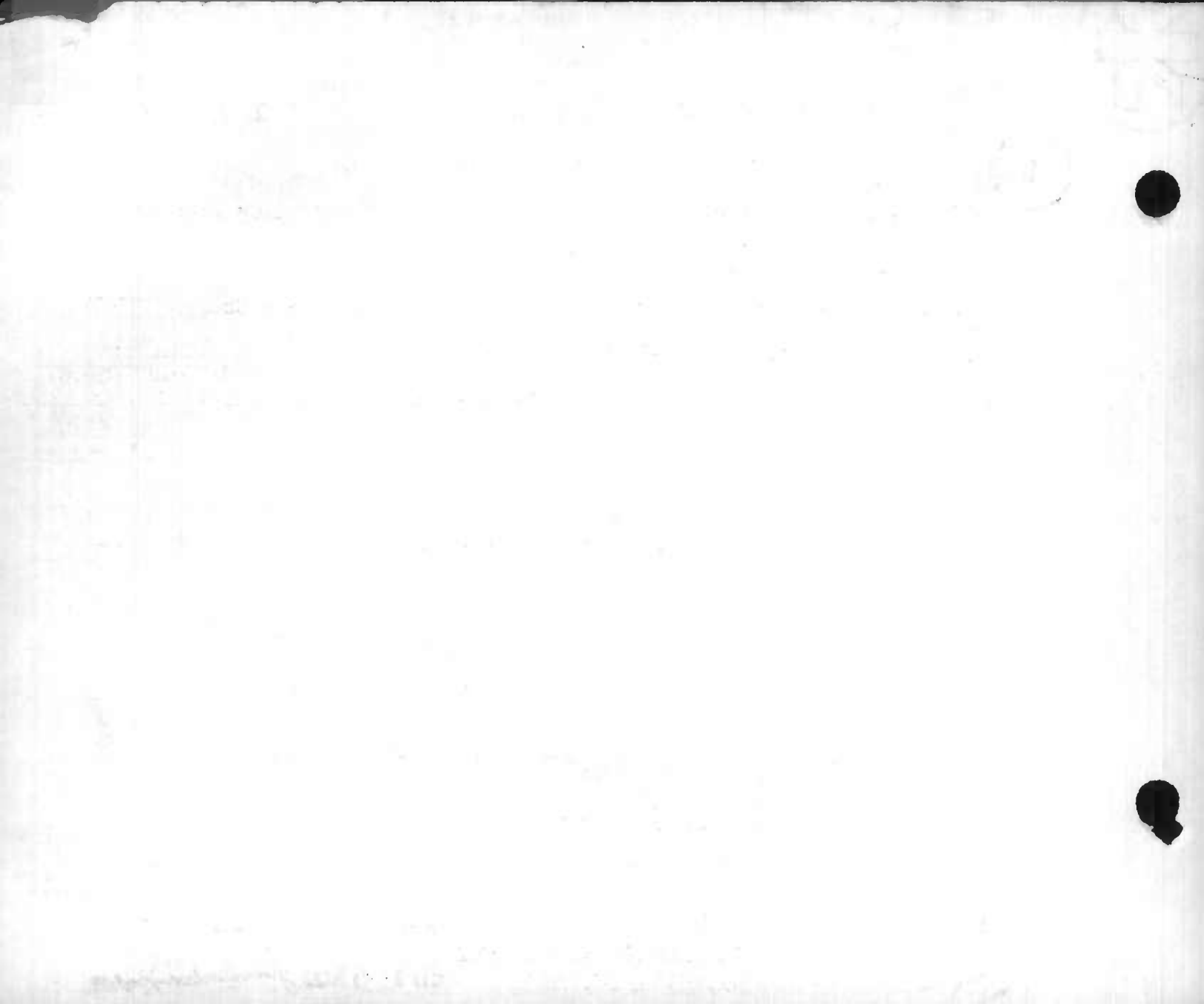
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

05665

1. DECEASED NAME (TYPE OR PRINT) Clara Lois CLARA Klionsky		2a. DATE OF DEATH MONTH DAY YEAR 2/12/85		2b. HOUR 1231 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 30, 1920	
6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator		12b. KIND OF BUSINESS OR INDUSTRY OFFICE		13. STREET ADDRESS / ZIP CODE 118 Monroe Street (20850)	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas A. Kelly		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Sulser		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-18-2833		17. INFORMANT ADDRESS Maryland 20879 Leesa Chais; 9319 Bathgate Court; Gaithersburg		18. CAUSE OF DEATH: Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Bronchitis</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>3-4 hr</u> <u>20 yr</u> <u>20 yr</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>January 30, 1985</u> to <u>2/12</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>January 30, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Co Stuart Scott MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <u>2/12/85</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Co Stuart Scott</u>		22e. ADDRESS <u>19201 Montgomery Vill. Ave. Gaithersburg</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/14/85		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn.	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Falls Church; Fairfax; Va.		24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS		25a. DATE REC'D. BY REGISTRAR FEB 1 5 1985	
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rosen</u>		25c. ADDRESS 1170 Rockville Pike; Rockville, Md. 20852			

BP

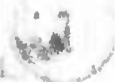


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Yoon Sun Koh										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2/26 19 85	
2. SEX Male		3. RACE Oriental		4. DATE OF BIRTH (MONTH DAY YEAR) Apr. 15, 1927		5. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		6. IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD 2/26 19 85	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea				7b. CITIZEN OF WHAT COUNTRY? Korea				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 824 Gregorio Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Officer		12b. KIND OF BUSINESS OR INDUSTRY Korea	
14. FATHER'S NAME FIRST MIDDLE LAST Moon Hak Koh										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Huh Koh	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-94-7490				17. INFORMANT ADDRESS Bong Hee Koh Wife Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u>											
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>None</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u>				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 2/26/85			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 28, 1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
500 University Blvd., W. Silver Spring, Md.						MAR 4 1985					



Year

Age

Sex

Color

Yellow Apr. 12, 1927 57

X

Montgomery County

Silver Spring 624 Oregon Drive

Maryland Montgomery Silver Spring 624 Oregon Drive

Cerebral vascular accident.

None

None

None

X

X

John S. Rogers, M.D.
Silver Spring, Montgomery, Md.
1919 Germany Road
Dorsey

2/26/25

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 6 7

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charlotte E. Kraabel			2a. DATE OF DEATH MONTH DAY YEAR February 23, 1985			2b. HOUR 3:15p M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate Agent		12b. KIND OF BUSINESS OR INDUSTRY Real Estate		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12 Cold Spring Court 20854	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Anderson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hulda not available							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 577-46-8413		17. INFORMANT Daughter		ADDRESS Elizabeth K. Ford Same as item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive Pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) attended the deceased from January 10, 1985 to February 23, 1985 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 21, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death.										
22b. SIGNATURE <i>Patricia D. Kellogg M.D.</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Feb. 23, 1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia D. Kellogg, M.D.						22e. ADDRESS 809 Viers Mill Road Rockville, Maryland 20851				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 27, 1985		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND						25. DATE REC'D. BY REGISTRAR FEB 28 1985				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3



WILLIAM BOND

100% COTTON FIBER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
Anna Margaret Kramer		February 5, 1985		9:45A _M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Caucasian	MONTH DAY YEAR	83 YRS	IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Germany	United States		Montgomery County MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY	
Potomac	9309 Garden Court		Homemaker	Own Home	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
Penna.		Delaware	Drexel Hill	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2574 Stoneybrook Lane/10026
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Franz Wernig			Margaret Rollman		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17 INFORMANT ADDRESS		
No		161-44-4711	Eleanor Appleton 9309 Garden Court Potomac, MD 20854		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebellar Tumor</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of the Lung</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>2 1/2 mos</u> <u>3 mos</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 19 <u>84</u> , to <u>2/5</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>12/17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Edward N. Gwozdz</u>		DEGREE		22c DATE SIGNED	
				Feb. 5, 1985	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
Edward N. Gwozdz, M.D.		600 New Hampshire Avenue, N.W. Washington, D.C. 20037			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE		
Burial	Feb. 9, 1985	Saints Peter & Paul Cemetery	Marple Township, Penna.		
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850		FEB 8 1985		<u>Julia Davidson-Randall</u>	



CHAPLAIN

BOARD

20X-CUT 100 FIBER

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT (PAGES 1, 2, 3, 4, 5) SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) Emmie McManus Kraus										2b. DATE KNOWN OF ESTI. DEATH MATED 2 14 1985				2d. HOUR P	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH 5 DAY 18 YEAR 18		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YR. MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 		2c. DATE PRONOUNCED DEAD 2 16 1985				2d. HOUR 14³⁰	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 166 New Mark Esplanade								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Traffic Director				12b. KIND OF BUSINESS OR INDUSTRY Broadcasting	
13a. STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 166 New Mark Esplanade			
14. FATHER'S NAME FIRST Clarence MIDDLE P. LAST Harwood				15. MOTHER'S MAIDEN NAME FIRST Patty MIDDLE LAST Mosby													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-05-4408				17. INFORMANT Eugenia E. Kraus Palo Alto, Ca. 94306									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): 																	
19a. DATE OF OPERATION 				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 								20. KIND AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 2 14 1985				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FOUND ON COUCH									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME				21f. LOCATION STREET 166 New Market Esp. CITY OR TOWN Rockville COUNTY Mont STATE MD									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE Francis C. Mayle				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER Francis C. Mayle M.D.				DATE SIGNED 2/17/1985 MD					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 8200 Wisconsin Ave., Bethesda,													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 19, 1985				23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park				23d. LOCATION CITY OR TOWN Rockville COUNTY Montgomery STATE MD.					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				ADDRESS Funeral Homes P.A. Rockville, MD				25a. DATE REC'D. BY REGISTRAR FEB 21 1985				25b. REGISTRAR'S SIGNATURE Davidson					

BP



UNITED STATES
NAVY

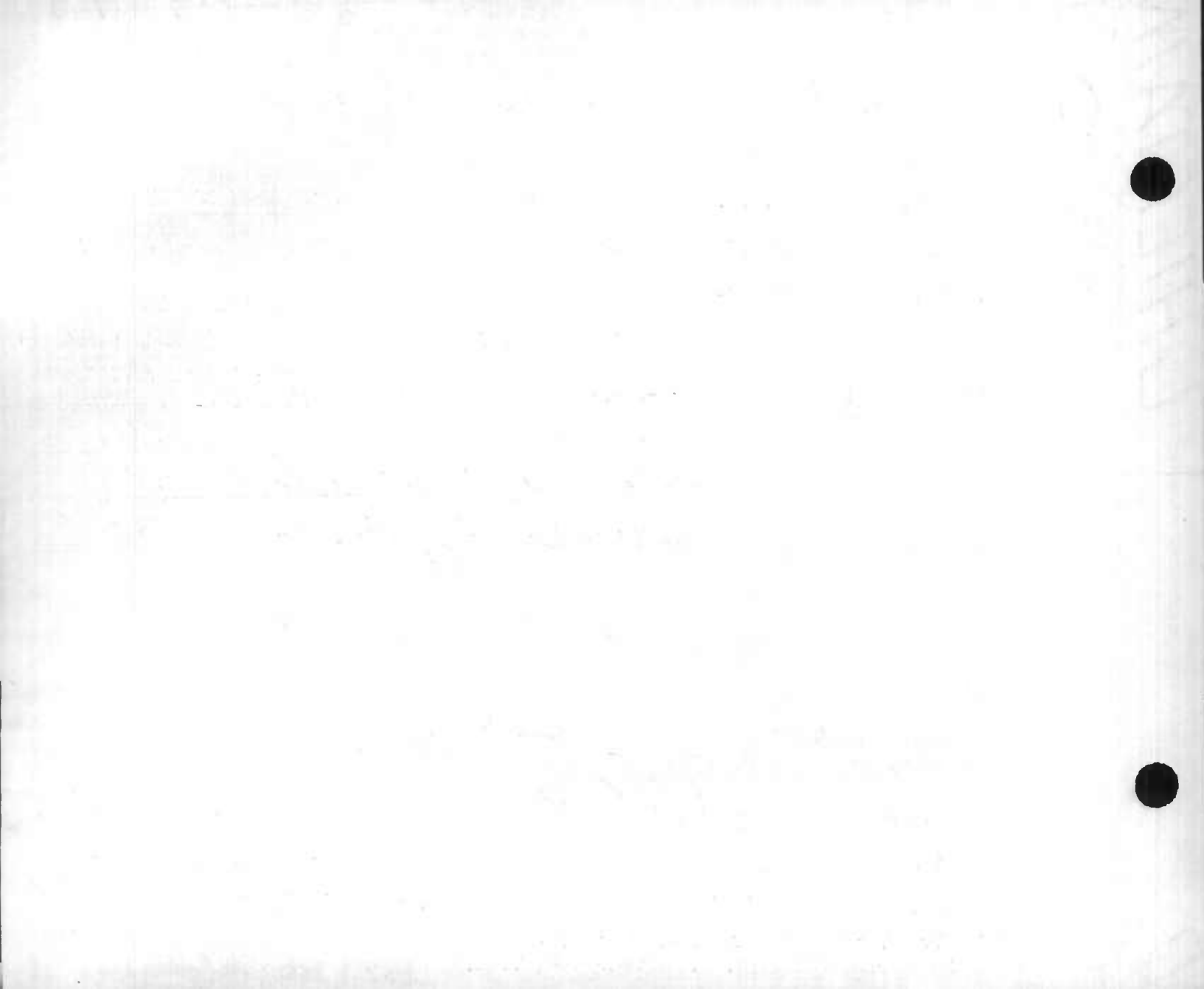


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) JOSEPH, KRAVITZ					2a. DATE OF DEATH MONTH FEBRUARY DAY 17 YEAR 1985		2b. HOUR 2p M		
3 SEX MA'LE		4 RACE WHITE		5. DATE OF BIRTH MONTH AUGUST DAY 28 YEAR 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DRIVER		12b. KIND OF BUSINESS OR INDUSTRY TAXI CAB	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5721 GROSVENOR LANE 20814	
14. FATHER'S NAME FIRST HYMAN MIDDLE LAST KRAVITZ				15. MOTHER'S MAIDEN NAME FIRST ETTA MIDDLE LAST (UNASCERTAINABLE)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-03-6948		17. INFORMANT ADDRESS EDWARD KRAVITZ, 3803 TREMAYNE TERRACE SILVER SPRING, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Plural effusion PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 					
22a. I certify that (I, we) we attended the deceased from Oct 79 to date 19 1985 , that (I, we) last saw the deceased alive on 2/17/85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) renew the body after death.									
22b. SIGNATURE Thos G. Ward		22c. DATE SIGNED 2/17/85				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD			
22e. ADDRESS 6116 ROBINWOOD		22f. ADDRESS Bethesda, 20817							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 2/18/1985		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION ADELPHI, PRINCE GEORGES, MARYLAND			
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR FEB 21 1985		25b. REGISTRAR'S SIGNATURE Julian Davidson			
23e. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.									



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 05671

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Rose N. Krejci</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Feb 16 1985</i>		2b. HOUR M <i>4 p</i>	
3. SEX <i>female</i>	4. RACE <i>Cauc.</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12 21 1892</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>92</i>	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Czechoslovakia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Beth Health Care Ctr</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Mont.</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Vincent Nespor</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Marie Vesely</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>099-14-2199</i>		17. INFORMANT ADDRESS <i>Otakar Krejci, same as #13</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <i>Acute Febrile Reaction</i> DUE TO, OR AS A CONSEQUENCE OF (b). <i>Viral Respiratory Infection</i> DUE TO, OR AS A CONSEQUENCE OF (c). <i>Chronic Debilitation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>June 30</i> , 19 <i>80</i> , to <i>Feb 16</i> , 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>Dec 23</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE <i>Robert T. Thibadeau</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2-16-85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROBERT T. THIBADEAU</i>				22e. ADDRESS <i>Rockville, Md 20852</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Feb. 20, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring, Maryland</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 21 1985</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Gendall</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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James
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

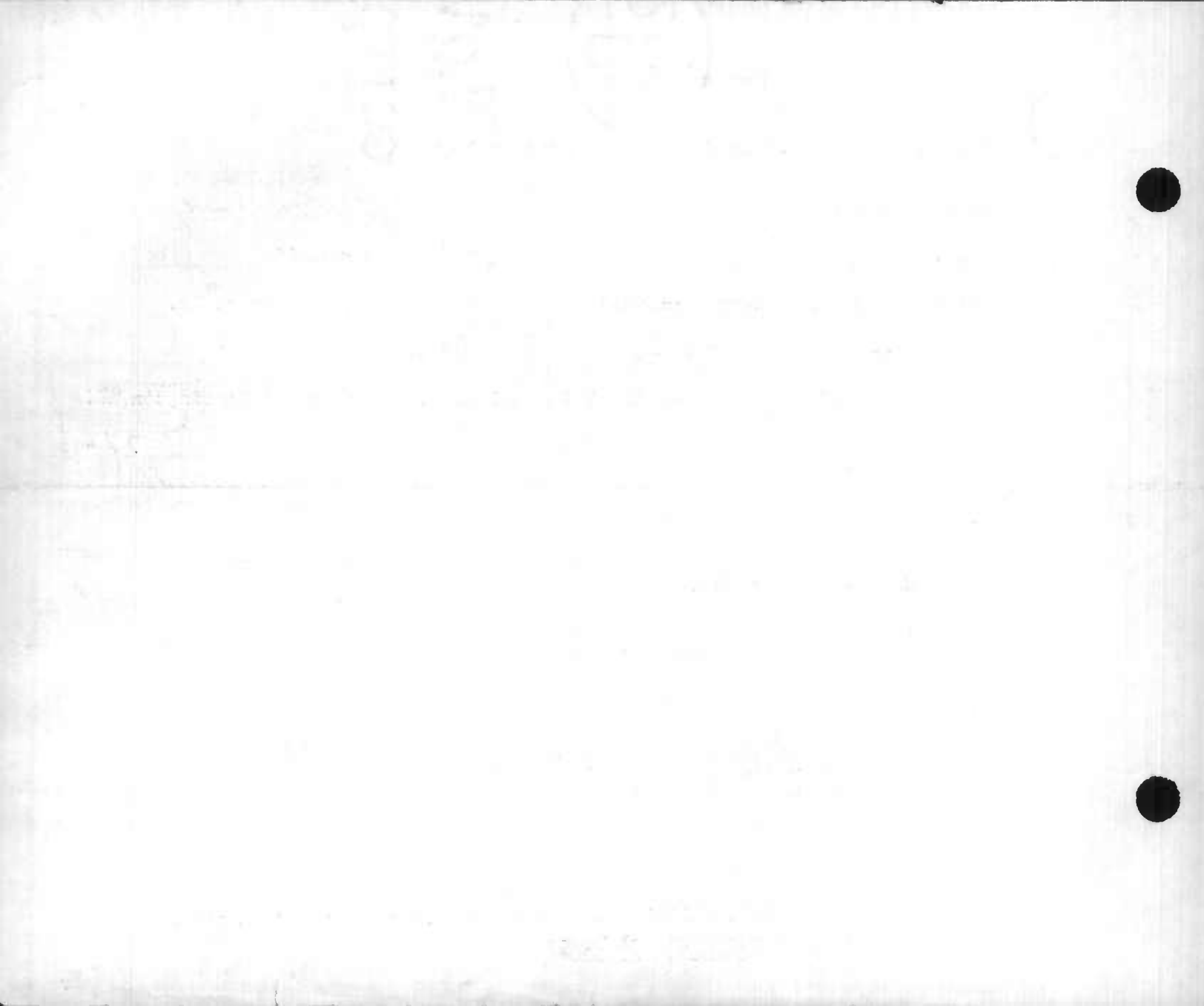
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ROSE KRISS				2a. DATE OF DEATH MONTH DAY YEAR 2 3 85 2b. HOUR 420 A.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH June 29, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13e. STREET ADDRESS / ZIP CODE			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Cohen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Getrude			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Helene K. Stolzberg 2700 Calgary Ave., Kensington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Multiple Myeloma							
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/2 19 85 , to 2/3 19 85 , that (I) (we) lost saw the deceased <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. above (I) (we) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE Raymond Bass				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/3/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND BASS				22e. ADDRESS 3929 Ferrara Dr Wheaton Md 20906			
23a. BURIAL, CREMATION, REMOVAL burial		23b. DATE Feb. 4, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt Lebanon Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi, Maryland	
24. FUNERAL DIRECTOR NAME Ives-pearson Funeral Homes Falsi Church, Va. 22046				25a. DATE REC'D. BY REGISTRAR FEB 7 1985		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST <i>Helen</i>	MIDDLE <i>T.</i>	LAST <i>Kulstad</i>	MONTH <i>2</i> DAY <i>25</i> YEAR <i>85</i>			3A M <i>34</i>		
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
		MONTH <i>July</i> DAY <i>15</i> YEAR <i>1899</i>	85 YRS.			MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Korea</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.						
10. CITY OR TOWN OF DEATH <i>Olney</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sharon Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Rockville</i>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST <i>Benjamin</i> MIDDLE <i>Walter</i> LAST <i>Thomas</i>			FIRST <i>Ostai</i> MIDDLE <i>-</i> LAST <i>Higuchi</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>None</i>			17. INFORMANT <i>George A. Kulstad (Son) Same as # 13</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

TERMINAL PULMONARY CONGESTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
TERM.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

CORONARY ATHEROSCLEROSIS YES
ARTEROSCLEROTIC HEART DIS. YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M.					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>							
22a. I certify that (1) (this hospital) attended the deceased from <i>12/21</i> 19 <i>82</i> to <i>2/25</i> 19 <i>85</i> , that (1) (we) lost <i>2/22</i> 19 <i>85</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <i>Donald R. Lewis</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/25/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DONALD R. LEWIS MD</i>		22e. ADDRESS <i>OLNEY MD 20832</i>					

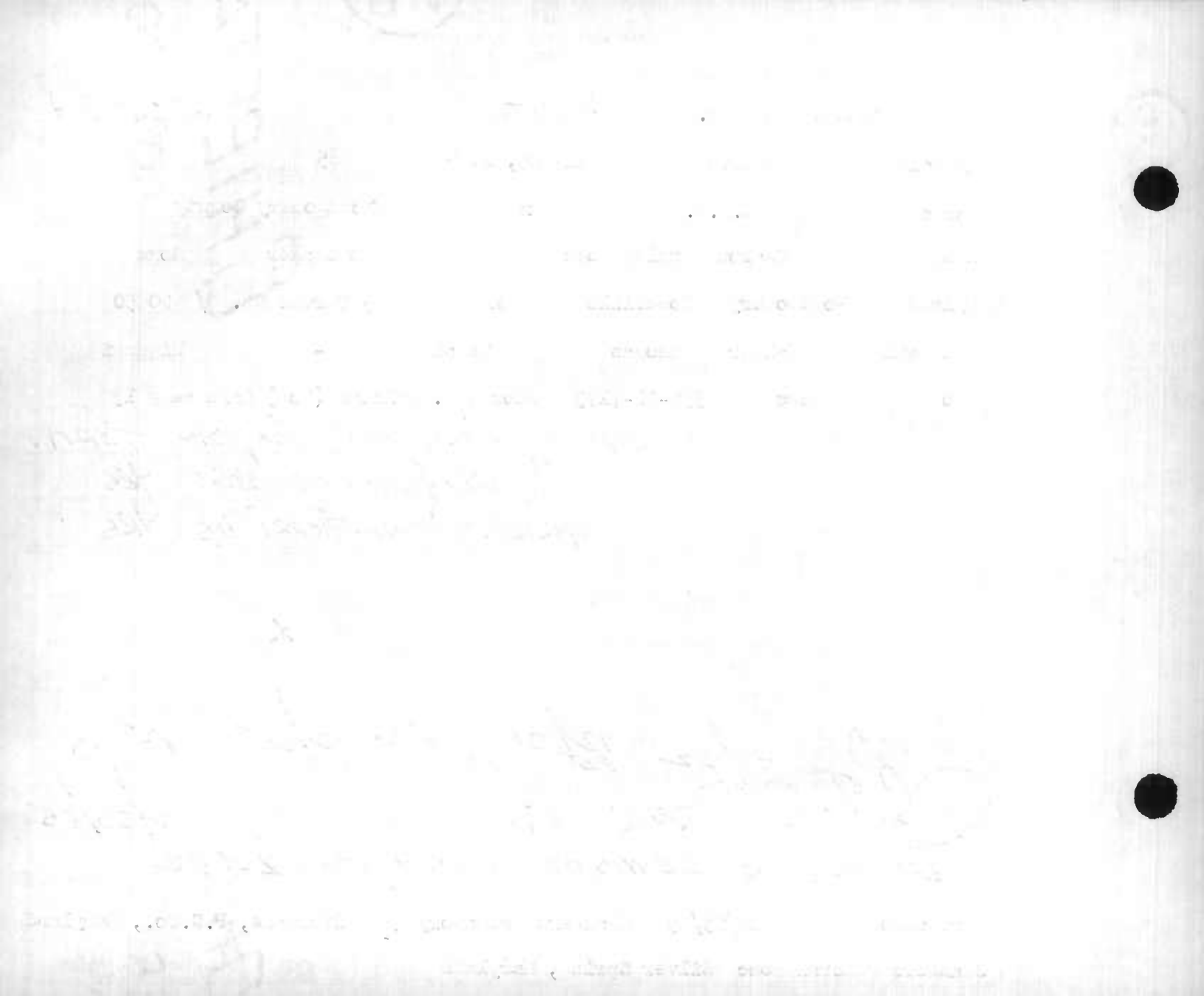
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>Feb/25/85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Chambers Crematory</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Riverdale, P.E.Co., Maryland</i>
24. FUNERAL DIRECTOR NAME <i>Chambers Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>MAR 1 1985 Julia Davidson-Randall</i>	
ADDRESS <i>Silver Spring, Maryland</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



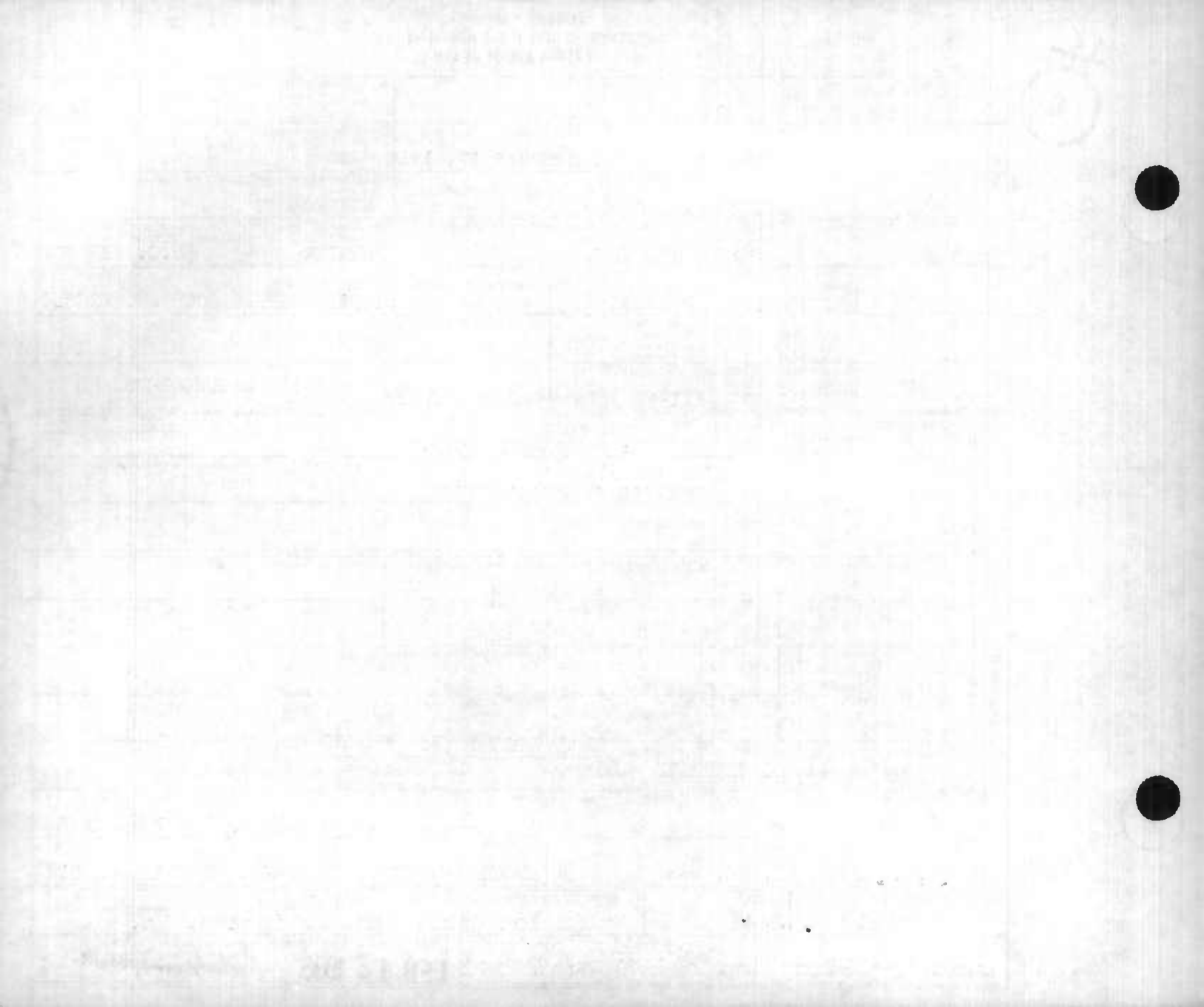
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL NMN KUSHNER			2a. DATE OF DEATH MONTH DAY YEAR FEB 06 85		2b. HOUR 2:36 a.m.				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 17, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. AIR FORCE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN POTOMAC		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST KARL NMN KUSHNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA UNKNOWN		13e. STREET ADDRESS / ZIP CODE 10313 GAINSBOROUGH RD. 20854					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-1967		17. INFORMANT Zelda KUSHNER		ADDRESS 10313 GAINSBOROUGH RD POTOMAC, MD			
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE PULMONARY INFARCTS DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE SYSTEM FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 21 JANUARY 19 85 , to 06 FEBRUARY 19 85 , that (I) (we) last saw the deceased alive on 06 FEBRUARY 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R.L. Nemecek</i>				DEGREE <i>MD</i>				22c. DATE SIGNED 7 Feb 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.L. NEMEC, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-11-1985		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem. Arlington, Va.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR FEB 13 1985		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CLARENCE L. KUYKENDALL			2a. DATE OF DEATH MONTH DAY YEAR Feb. 22, 1985		2b. HOUR P 10:45 ^P	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MAY 14 ^{AY} , 1892		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENN.		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS LAST BIRTHDAY) 92		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel-Pre Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
12a. USUAL OCCUPATION (TYPE OR VARIOUS FORMS OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION				
13a. STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		
14. FATHER'S NAME FIRST MIDDLE LAST ALFRED KUYKENDALL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH E. LAYMANS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 578-24-3622		17. INFORMANT ADDRESS Stella D. Kuykendall SAME AS #13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alzheimer's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 5 yr.
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 19 85</u> , to <u>Feb 22 85</u> , that (I) (we) last saw the deceased alive on <u>Feb 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u> MD				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED 2-23-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Kellant, MD				22e. ADDRESS 4000 Olney Laytonville Rd. Olney, MD. 20832			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 26, 1985		23c. NAME OF CEMETERY OR CREMATORY Burtonsville Union		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Mont. Md.	
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR MAR 01 1985			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ALORA

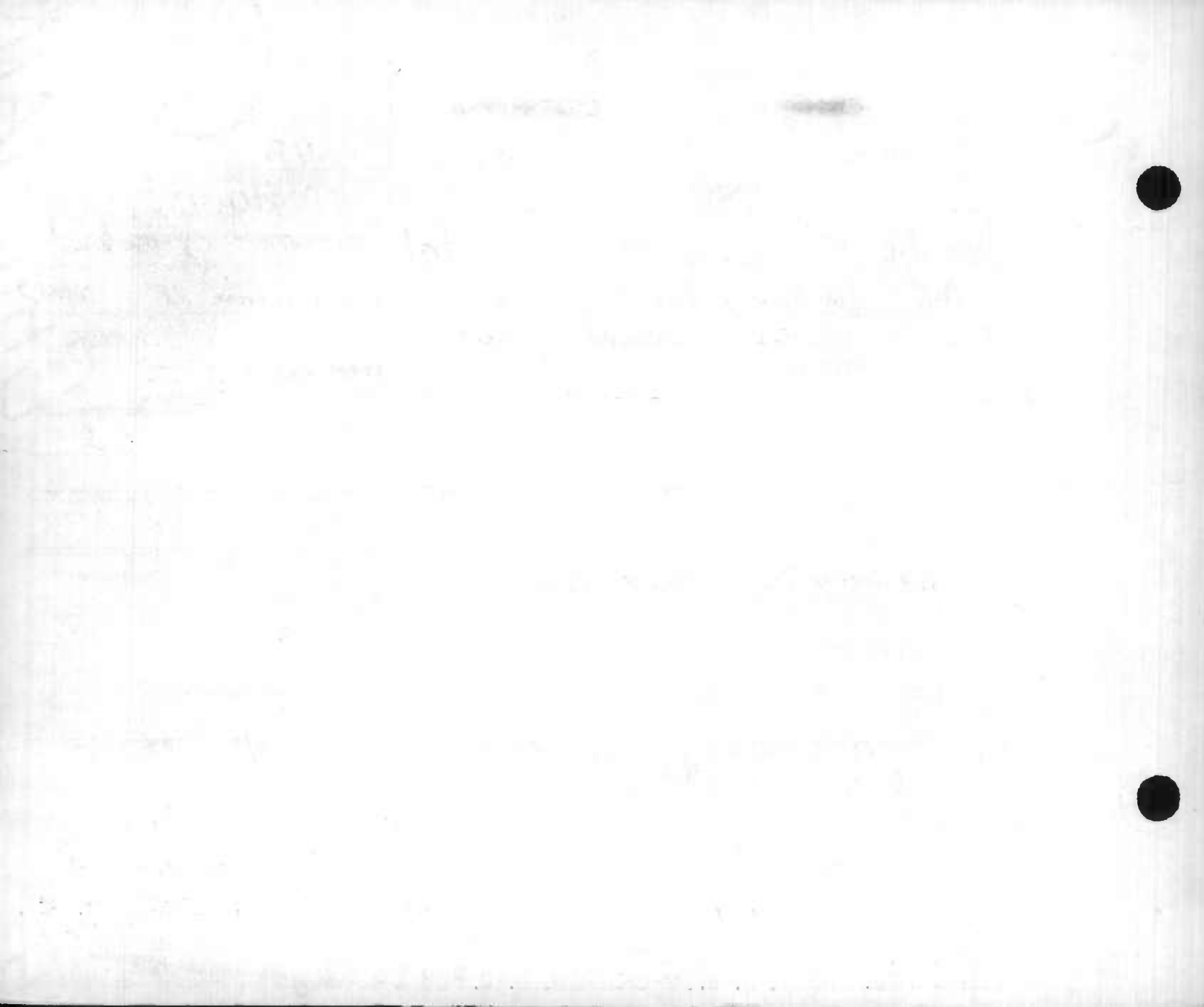
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/83
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) SADIE		3. DATE OF DEATH MONTH 2 DAY 8 YEAR 85	
3. SEX Female			4. RACE white		5. DATE OF BIRTH MONTH 12 DAY 27 YEAR 1891	
7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA			7b. WHAT COUNTRY? RUSSIA		8. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) Suburban Hospital		12a. BALTIMORE CITY OR COUNTY OF DEATH Montgomery City	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD 13c. COUNTY Montgomery 13d. CITY OR TOWN Rockville			13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE 6121 mantrose Rd 20852	
14. FATHER'S NAME FIRST SHOLOM MIDDLE MORDECAI LAST RIMMERMAN			15. MOTHER'S MAIDEN NAME FIRST FREDA MIDDLE REZIA LAST KANOWITZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 579-48-4102D		17 INFORMANT HERB LIEF, 11801 ROCKVILLE PIKE, ROCKVILLE, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper Gastrointestinal bleeding DUE TO, OR AS A CONSEQUENCE OF (b) Marginal Ulcer DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 d
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/83 , 19 85 , to 2/8 , 19 85 , that (I) (we) last saw the deceased alive on 2/7 , 19 85 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE Peter B. Sherer		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/8/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter B. Sherer MD		22e. ADDRESS 3947 Ferrara Dr. Wheaton MD				
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 2/10/1985		23c. NAME OF CEMETERY OR CREMATORY BETH SHOLOM CONGREGATION CEMETERY		
23d. LOCATION CITY CAPITOL HEIGHTS, PR. GEO. STATE MD		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE FEB 13 1985				
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM E. LANCASTER			2a. DATE OF DEATH MONTH DAY YEAR 2-09-85			2b. HOUR 0010 A M				
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1-10-07		6. AGE (IN YEARS LAST BIRTHDAY) * 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Government		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Montg		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 24 Orchard Rd. 20878	
14. FATHER'S NAME FIRST MIDDLE LAST Isaiah Lancaster			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Claggett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215202744		17. INFORMANT ADDRESS Florence Lancaster (sister)		SAME AS 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Communicating Hydrocephalus

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/5/85 , 19____, to 2/9/85 , 19____, that (I) (we) last saw the deceased alive on 2/9/85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ismael Perre				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 2-14-85		23c. NAME OF CEMETERY OR CREMATORY Knory Grove Cem.		23d. LOCATION (CITY OR TOWN) COUNTY STATE Gaithersburg Montg Md.	
24. FUNERAL DIRECTOR NAME George R. Snowden				25. DATE RECEIVED BY REGISTRAR FEB 13 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or checked as injury, or other traumatic event, the medical examiner must be notified.



DEED

1000

1000

1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 25 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILTON CHARLES LANG						7a. DATE OF DEATH MONTH DAY YEAR 2/6/85		7b. HOUR 6:30 A.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 10-2-1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		8. IF UNDER 1 YEAR MONTHS DAYS		9. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WILSON HEALTH CARE CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Doctor		12b. KIND OF BUSINESS OR INDUSTRY Medicine			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 403 Russell Ave. # 412 20877			
14. FATHER'S NAME FIRST MIDDLE LAST George Eugene Lang				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Maria Troutmann							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-44-4382		17. INFORMANT Dr. Robert Parker				ADDRESS 401 Russell Ave., Gaithersburg, Md. 20877			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Artery Disease										yes	
(c) Arteriosclerosis										yes -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/31/85 to 2/6/85 , that (I) (we) last saw the deceased alive on 1/31/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE Thos B. Ward		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/6/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos B. WARD		22e. ADDRESS 6116 Belvidere, Bethesda, Md 20817									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/8/85		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balt. Md.					
24. FUNERAL DIRECTOR Rosabel Sandison 316 E. Diamond Ave. FEB 11 1985 Gartner Sandison F.H. Gaithersburg, Md. 20877											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

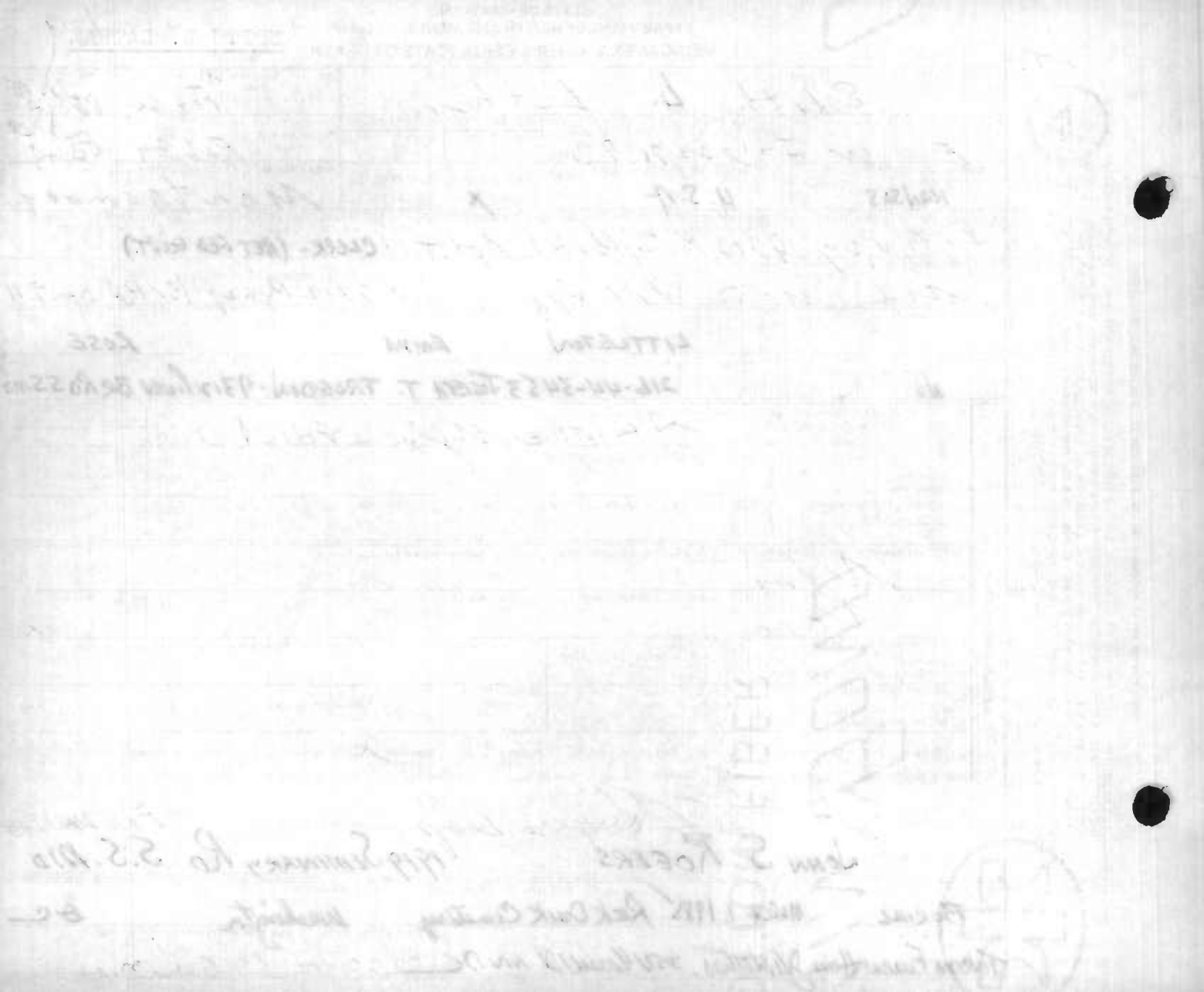
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

EDITH L. LATHAM

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edith L. Latham						2a. DATE KNOWN OF DEATH ESTIMATED Feb 24 1985		2b. HOUR 11:00 A M	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR July 22 1921	6. AGE (IN YEARS) (LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD Feb 24 1985	7d. HOUR 11:00 A M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KANSAS		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Monterey MD			
10. CITY OR TOWN OF DEATH S. E. Spg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9312 Piney Br Rd Apt. T-11				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK - (RET FED GOVT.)		12b. KIND OF BUSINESS OR INDUSTRY 20910	
13a. STATE MD		13b. COUNTY MOND.		13c. CITY OR TOWN S. E. Spg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 9312 Piney Br Rd Apt T-11			
14. FATHER'S NAME FIRST MIDDLE LAST LITTLETON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA ROSE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 216-44-3453		17. INFORMANT ADDRESS JOSEPH T. TROGDON - 9312 PINEY BR RD SSMO				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None									
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John S. Rogers			TITLE (SPECIFY) John S. Rogers M.D.			MEDICAL EXAMINER DATE SIGNED Feb 24 1985			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS			ADDRESS 1919 SEMINARY RD. S.S. MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MARCH 1, 1985		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.		
24. FUNERAL DIRECTOR NAME Takoma Funeral Home, J. A. Walker			ADDRESS 254 Carroll St NW DC			DATE REC'D. BY REGISTRAR FEB 28 1985			
						REGISTRAR'S SIGNATURE P. A. ...			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST SALVATOR		MIDDLE		LAST LAURIA		2a. DATE KNOWN OF DEATH			
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD			
NEW YORK			U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery MD.		Feb 22 1985			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney			Montgomery Memorial Hosp						FEDERAL GOV'T		GOVERNMENT	
13a. STATE				13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
MARYLAND				MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15524 Prince Frederick Way		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					ADDRESS		
FIRST MIDDLE LAST					FIRST MIDDLE LAST					15524 Pr. Frederick W		
ROCCO					LAURIA					CIRIGLIANO		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.					17. INFORMANT		
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					Army WW II					059-03-9985 Ethel R. Lauria-Wife Silver Spring, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Pulmonary Embolism												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
(b) Fracture L. hip										3 days		
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
None												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
2-22-85				Fracture L. hip				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED				
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				HOUR A.M. MONTH DAY YEAR				ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2				
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				Home				Slipped on rug at home				
22a. I certify that I took charge of the remains described above, held on				Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
death resulted from:				Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED				
John S. Rogers				M.D. Dep				Feb 28 1985				
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								
JOHN S. ROGERS				1919 Seminary Rd. Silver Spring, Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION				
Burial			03/04/85		Gate of Heaven Cemetery			Silver Spring Montgomery MD				
24. FUNERAL DIRECTOR NAME			11800 New Hampshire Ave			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Hines/Rinaldi F.H.			Silver Spring, Maryland			MAR 4 1985			L. Davidson-Randall			

RECEIVED

(4)

2022 COLLOID LIFEM

MAR 4 1988

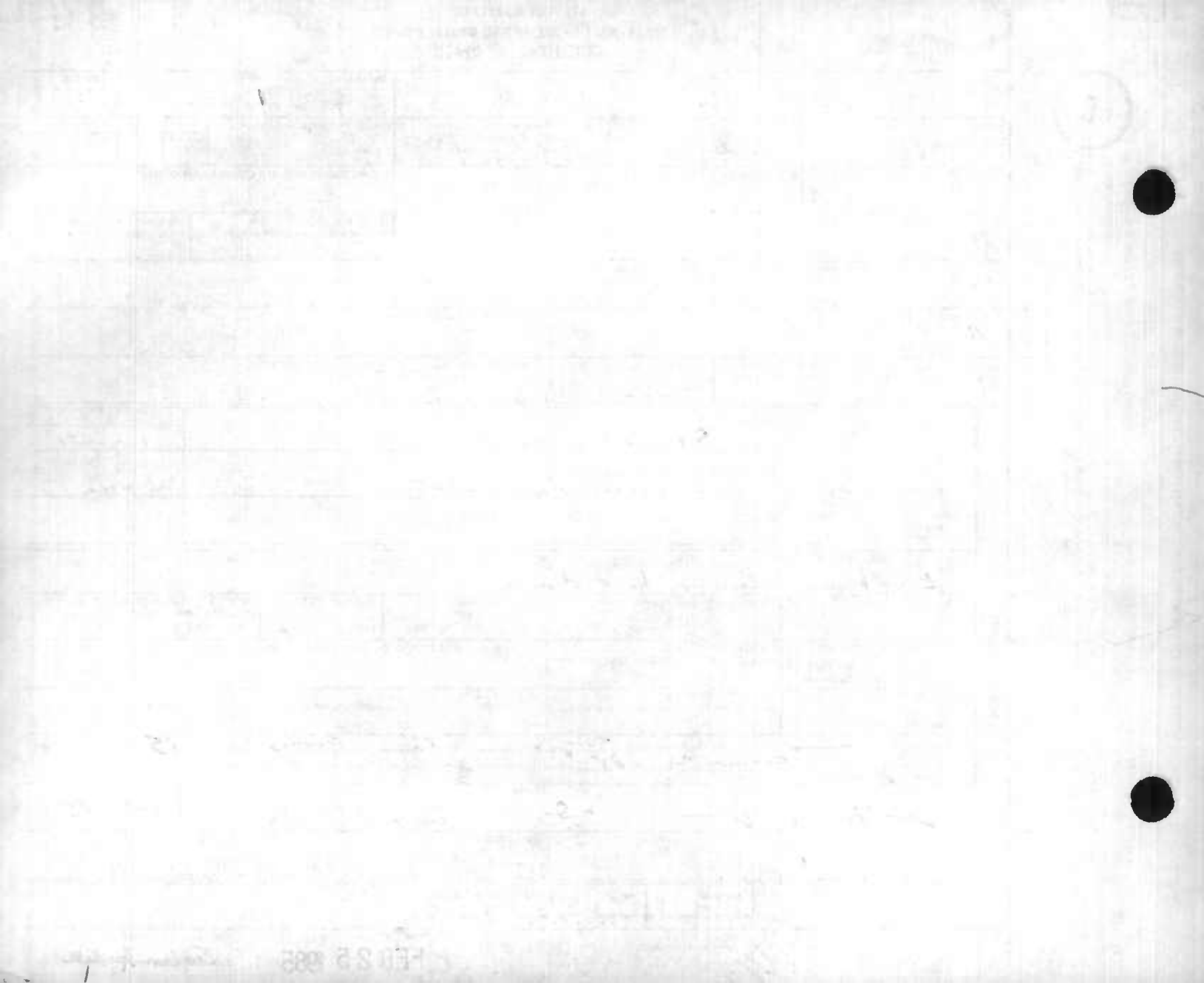
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Pearl M. Layfield				2a. DATE OF DEATH MONTH DAY YEAR February 24, 1985			
3 SEX Female				2b. HOUR 10:10 P M			
4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR July 15, 1897		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3503 Stark Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Crossing		12b. KIND OF BUSINESS OR INDUSTRY Guard	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Abraham Gooden		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Hess		13e. STREET ADDRESS 3503 Stark Street		13f. ZIP CODE 20895	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-40-7758		17 INFORMANT Son-in-Law		17 ADDRESS Same as 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory arrest							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular accident							1 week
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Emphysema Coronary heart disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from July 6, 1981 , to February 24, 1985 , that (I) (we) lost saw the deceased alive on February 24, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22a. SIGNATURE Sidney I. Cohen				DEGREE M.D.		22c. DATE SIGNED 2-22-85	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney I. Cohen, M.D.				22d. ADDRESS 121 Congressional Lane Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 25, 1985		23c. NAME OF CEMETERY OR CREMATORY I.O.O.F.		23d. LOCATION CITY OR TOWN COUNTY STATE Cairo Ritchie West Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS Francis J. Collins 500 University Blvd., W. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR FEB 25 1985		25b. REGISTRAR'S SIGNATURE Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 48, then any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)			MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
Thomas Francis Leahey			February 14, 1985		650 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male	White	Jan. 31, 1909	76 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
New York	U.S.A.		Montgomery County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring	15145 Vantage Hill Road		Economist		U.S. Gov't. Treasury Dep't.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15145 Vantage Hill Road 20906	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
Thomas Leahey			Mary O'Brien			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes			WW II 216/44/4295		Silver Spring, Md 20906	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest			minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive Pulmonary Disease, 20 years						
DUE TO, OR AS A CONSEQUENCE OF (c) Lung Cancer, Aspiration Pneumonia,			2 months.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Polymyalgia Rheumatica, malnutrition, Seizure Disorder, Probable Brain Lesion.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
		HOUR A.M. MONTH DAY YEAR				
		P.M. 19				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4-26-83, to 2-14-85, that (I) (we) saw the deceased alive on 12-8-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE				DEGREE		22c. DATE SIGNED
Oliver J. Lawless MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2-14-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
OLIVER J. LAWLESS MD				LEISURE WORLD MEDICAL Center		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Removal		2-14-85		Geo. Wash. U. Med. Sch.		CITY OR TOWN COUNTY STATE
				Washington		D.C.
24. FUNERAL DIRECTOR				25. DATE REC'D. BY REGISTRAR		
COLUMBIA MORTUARY SERVICES WASH., D.C. 20001				26. REGISTRAR'S SIGNATURE		
				John D. Anderson		

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR										7a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) JOSEPH THEODORE LEAKS, JR.										2. DATE KNOWN OF DEATH 2 23 1985	
3. SEX MALE										2b. HOUR 01	
4. RACE B										2c. DATE PRONOUNCED DEAD 2 23 1985	
5. DATE OF BIRTH 12/6/42										2d. HOUR 01	
6. AGE (IN YEARS) 42 YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH BETHESDA										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Equipment Operator										12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE MD										13b. CITY OR TOWN FREDERICK	
13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										13d. STREET ADDRESS 6003 MANOR WOODS RD	
14. FATHER'S NAME Joseph Theodore Leaks, Sr.										15. MOTHER'S MAIDEN NAME Mary Frances Weedon	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 218-38-2104	
17. INFORMANT Thelma F. Leaks, Frederick, MD. 21701											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION _____										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____	
20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 0045 AM 2 23 1985										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED WHILE DRIVING	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) STREET	
21f. LOCATION CONN. AVE & BEAUMONT										21g. CITY OR TOWN BETHESDA	
21h. COUNTY MONT.										21i. STATE MD	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Francis C. Mayle										TITLE (SPECIFY) DEPT	
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C. MAYLE										DATE SIGNED 2-23-85	
ADDRESS 2200 Wisconsin Ave Bethesda MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 3/1/85	
23c. NAME OF CEMETERY OR CREMATORY Sunnyside Cemetery										23d. LOCATION Adamstown, Frederick, MD.	
24. FUNERAL DIRECTOR Donna Stapp										25a. DATE RECD BY REGISTRAR MAR 5 1985	
ADDRESS 1621 Opasstown Pike										25b. REGISTRAR'S SIGNATURE Donna Stapp	

DATA MINING

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10100 202

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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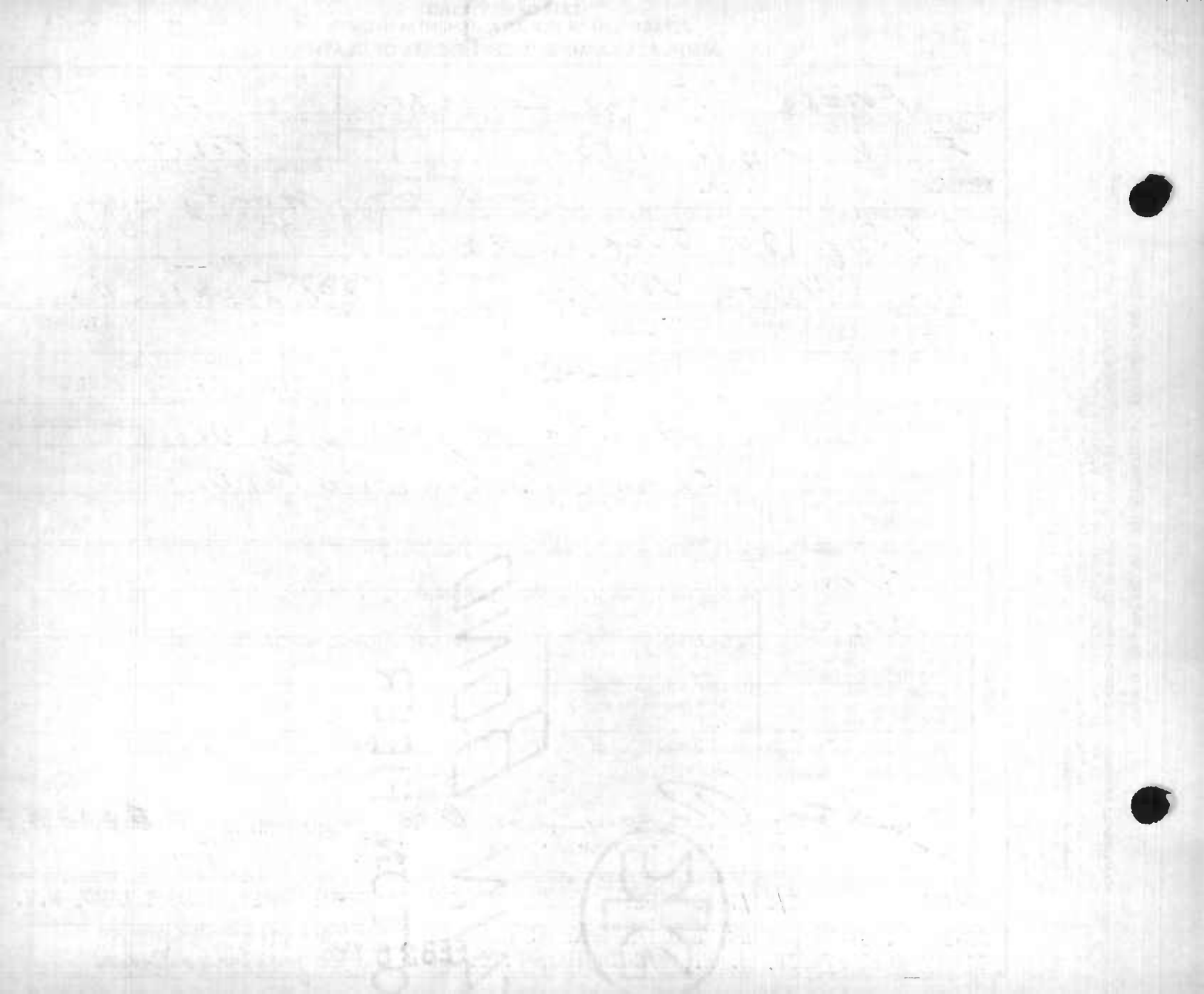
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Frieda Fanny Lebetkin			2a. DATE KNOWN OF DEATH ESTIMATED Feb. 19 1985			2b. HOUR 5 P		
3. FEMALE F	4. WHITE W	5. DATE OF BIRTH MONTH DAY YEAR Aug 15 01 83	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 83	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD Feb. 19 1985	7d. HOUR 5 P	
7a. BIRTHPLACE (STATE OR COUNTRY) RUSSTIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) 201 Jackson Rd			12a. USUAL OCCUPATION (TYPE OF WORK) HOUSEWIFE		12b. KIND OF BUSINESS OWN HOME	
13a. STATE MD		13b. COUNTY Mont	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 201 Jackson Rd			
14. FATHER'S NAME SAMUEL MIDDLE HOLZMAN				15. MOTHER'S MAIDEN NAME ANNA MIDDLE DOLIANKO				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (IF YES, GIVE WAR OR GATES)		16b. SOCIAL SECURITY NO. 129-14-4332 D		17. INFORMANT MIRIAM GRUBER, 901 JACKSON ROAD SILVER SPRING, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Chronic Obstructive Pul. Dis. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE DR. JOHN S. ROGERS, M. D.		TITLE (SPECIFY) M.D.		DATE Feb. 20 1985		MEDICAL EXAMINER 1919 SEMINARY ROAD SILVER SPRING, MARYLAND		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS						
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 2/22/1985		23c. NAME OF CEMETERY OR CREMATORY BETH MOSES CEMETERY		23d. LOCATION FARMINGDALE, LONG ISLAND, N.Y.		
24. FUNERAL DIRECTOR OR EXAMINER DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CA ROLL STREET, N. W., WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR FEB 25 1985		25b. REGISTRAR'S SIGNATURE Julia Friedman-Randall		



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

05685

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William B. Lee			2a. DATE OF DEATH MONTH DAY YEAR 2 25 85			2b. HOUR 01 55 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 20 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret'd Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Montg. Cty.		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 50 W. Deerpark #102 20877	
14. FATHER'S NAME FIRST MIDDLE LAST George W. Lee			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Jane Ely							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 223-10-3940A		17. INFORMANT Sarah Marie Lee 50 W. Deerpark Dr. #102 Gaithersburg, Md. 20877					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gastro-intestinal bleeding

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) Peptic Ulceration

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 days

6 weeks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

Chronic obstructive pulmonary disease

19a. DATE OF OPERATION 1-15-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Ulcer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>Dec 2-22</u> , 19 <u>85</u> , to <u>2-25</u> , 19 <u>85</u> , that (we) lost saw the deceased alive on <u>2-22</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Paul Kraft</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-25-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Paul Kraft</u>		22e. ADDRESS <u>2101 Med Hill Drive Straberg 20402</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/27/85		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg. Md.	
24. FUNERAL DIRECTOR NAME Gartner Sandison F.H.		316 E. Diamond Ave. Gaithersburg, Md. 20877		25a. DATE REC'D. BY REGISTRAR 28 1985		25b. REGISTRAR'S SIGNATURE <u>John Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal case must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST YU MEI H. LEE					2a. DATE OF DEATH MONTH DAY YEAR 2/8/85			2b. HOUR 12 ⁰⁰ A.M.		
3. SEX FEMALE		4. RACE ORIENTAL		5. DATE OF BIRTH MONTH DAY YEAR 9/29/29		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canton, China		7b. CITIZEN OF WHAT COUNTRY? China		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food service aide		12b. KIND OF BUSINESS OR INDUSTRY Hot Shoppes		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jack Yee On					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kim - Tam					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 550-06-7301		17. INFORMANT ADDRESS 22030 Wai Man Lee (Son) 4313-Lamare Dr., Fairfax, VA						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cancer breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH h										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 7 1985</u> to <u>Feb 8 1985</u> , that (I) (we) lost <u>see the deceased alive on</u> <u>Feb 7 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.										
22b. SIGNATURE MARTIN WEITZ 7525 Greenway Cir Germantown MD 20770				DEGREE ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/8/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 11, 1985		23c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery, Suitland, P.G., Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ELAINE D LEHR			2a. DATE OF DEATH MONTH DAY YEAR 2/25/85		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8/23/25		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Program Analyst		12b. KIND OF BUSINESS OR INDUSTRY HHS
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS - ZIP CODE 1016 Loxford Terrace 20901	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Deskin			15. MOTHER'S MAIDEN NAME MIDDLE LAST Belte Yochelson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Husband: Richard Lehr same as #13	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) MULTIPLE MYELOMA. DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) PNEUMONIA. Amyloidosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 2/2 19 85 , to 2/25 19 85 , that (1) (we) lost saw the deceased alive on 2/25 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alan Diamond		DEGREE MD		22c. DATE SIGNED 2/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN DIAMOND		22e. ADDRESS 1106 SPRING ST SILVER SPRING MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 28, 1985		23c. NAME OF CEMETERY OR CREMATORY Lebanon Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi, Maryland		25a. DATE REC'D BY REGISTRAR MAR 05 1985			
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes		25b. REGISTRAR'S SIGNATURE John Davidson			
Falls Church, Va. 22046					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Annie M. Leininger			2a. DATE OF DEATH MONTH DAY YEAR 2 24 85			2b. HOUR 10¹⁵ AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 24, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF ANY, GIVE STREET ADDRESS) Sharon Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5900 Chatsworth Lane 20814	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda			
14. FATHER'S NAME FIRST MIDDLE LAST John Ora Marshall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Elizabeth White			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 560-56-0937		17. INFORMANT ADDRESS Mary Ann Bowen same as 13e			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exoncho pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) 5 days years		APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Schizophrenia Personality

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 15 2/24 85			
22a. I certify that (I) (this hospital) attended the deceased from 2/23 19 85 , to 2/24 19 85 , that (I) (we) saw the deceased alive on 2/23 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. H. Leininger		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/24/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. Leininger		22e. ADDRESS 1841 Pk. Philip Dr. Olney MD 20852					

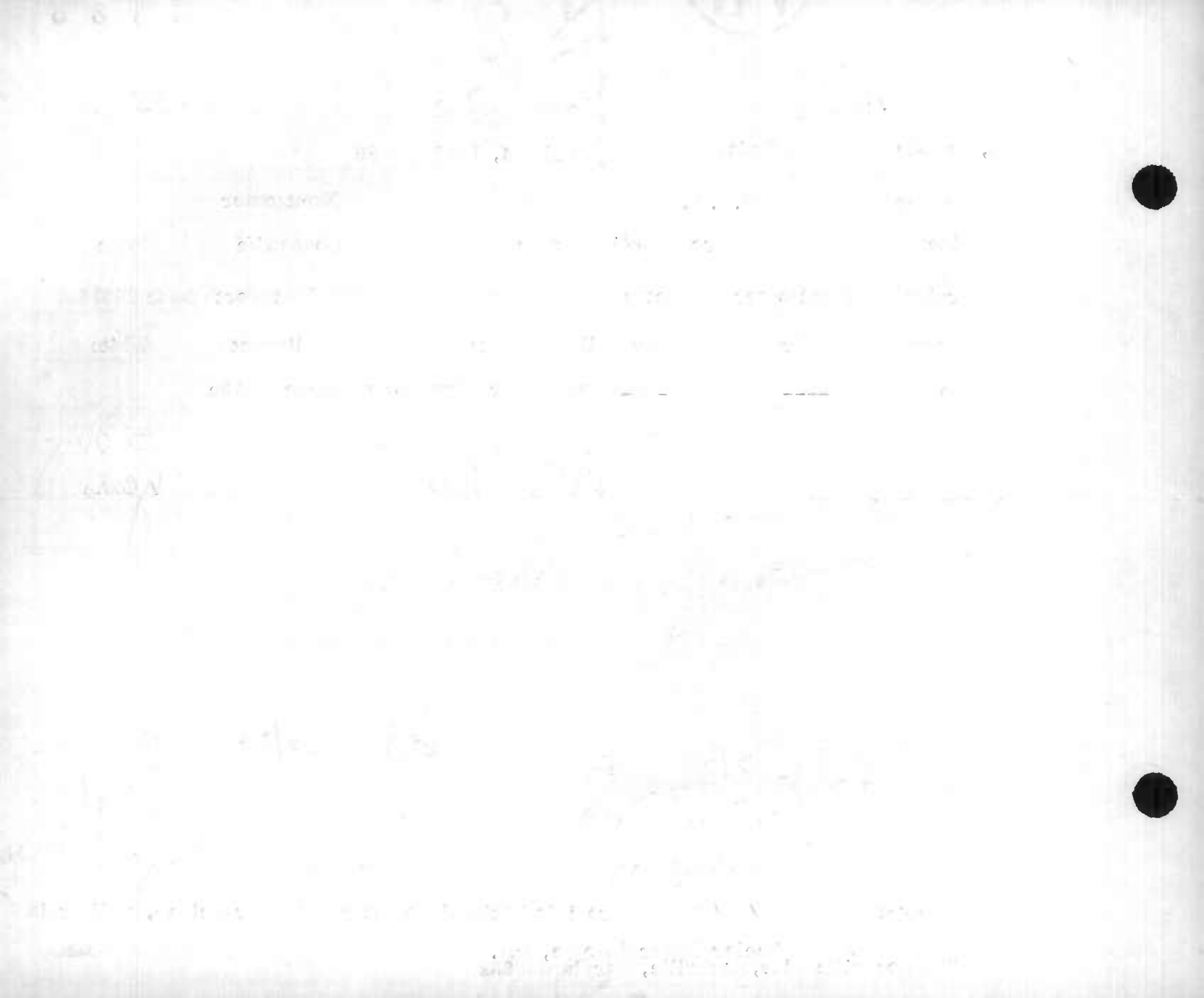
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/28/86		23c. NAME OF CEMETERY OR CREMATORY Presidio National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE San Francisco, California	
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24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.		25. DATE RECEIVED BY REGISTRAR MAR 1 1985		25b. REGISTRAR'S SIGNATURE J. H. Davidson	
1331 Rockville Pike, Rockville, Maryland 20852					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH TWO COPIES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2. DATE KNOWN OF DEATH (MONTH DAY YEAR)		
Charles I Lempke Sr									Feb 27 1985		
3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS) (LAST BIRTHDAY)	7. IF UNDER 1 YR. (MONTHS DAYS)	8. IF UNDER 24 HRS. (HOURS MIN)	9. DATE OF DEATH (MONTH DAY YEAR)			10. HOUR (M A P M)		
M	W	OCT 26 1919	65 YRS.			Feb 27 1985			12 45 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
WASH. DC.			USA						Montgomery MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Y. Spg			11 Oldham Rd			Elec. ENGINEER			Electrical		
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md			Montgomery			11 Oldham Rd			20901		
14. FATHER'S NAME (FIRST MIDDLE LAST)			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Charles A. Lempke			Bertha Sandlers			YES			1942 1984		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
T. Lempke			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			None			None		
ADDRESS			PART 1 DEATH WAS CAUSED BY:			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
9326 Hickory lmb Columbia Md.			IMMEDIATE CAUSE (a) Acute myocardial Dis.								
			DUE TO, OR AS A CONSEQUENCE OF								
			(b) Chronic Cardio. Pul. Dis.						Yrs		
			DUE TO, OR AS A CONSEQUENCE OF								
			(c)								
			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
			None								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			22b. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			22c. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			22d. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
CREMATION			2/28/85			Balt. Wash. Crematory			Laurel PG Md.		
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
FIECK FUNERAL HOME INC. 7601 SANDY SPRING Rd. Laurel Md. 20707			MAR 4 1985			Julia Davidson					

ORIGINAL



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Edward John Leonard			2a. DATE OF DEATH MONTH DAY YEAR February 14, 1985			2b. HOUR 11⁴⁰ AM					
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 28, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5301 Moorland Lane				12a. USUAL OCCUPATION International President/Plasterers & Cement Masons International Union		12b. KIND OF BUSINESS OR			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5301 Moorland Lane / 20814		
14. FATHER'S NAME FIRST MIDDLE LAST Not Available			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kramer			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 208-10-6214A	
17 INFORMANT ADDRESS Mrs. Marcella M. Leonard, Wife, Same as #13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) coronary heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 12/23 , 19 84 to 2/14 , 19 85 , that (2) (we) last saw the deceased alive on 1/29 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James Brodsky, M.D. THE PHYSICIAN'S NAME (TYPE OR PRINT)			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Feb. 14, 1985		
22d. ADDRESS 4701 Willard Ave. Chevy Chase, Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE February 20, 1985		23c. NAME OF CEMETERY OR CREMATORY St. Augustine Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Shaler Township, Pennsylvania				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland			25a. DATE REC'D. BY REGISTRAR FEB 21 1985			25b. REGISTRAR'S SIGNATURE Licia Davidson-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the 72 hours of receipt with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

PO: COTTON FIBER

DAVE R. M.

DAVID

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8505691

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carrie LaVerne Leshner			2a. DATE OF DEATH MONTH DAY YEAR 2 6 85		2b. HOUR 750 A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB 4 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CARLISLE, PA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.		13b. COUNTY MONT	13c. CITY OR TOWN OLNEY, MD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE BROOK GROVE RD 20832
14. FATHER'S NAME FIRST MIDDLE LAST LEVI ADAMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISY TAWZER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NOT AVAILABLE		17. INFORMANT DAVID LUTHER LESHNER, (SAME AS 13e)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Cardio Pulmonary Arrest
Cerebral Vascular Accident

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
10 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

Multiple strokes @ Seizures @ Urinary tract infection @ Sepsis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 2/5, 1985 to 2/6/1985, that (I) (we) lost saw the deceased alive on 2/5, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alan R. Gair MD		DEGREE		22c. DATE SIGNED 2/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN R. GAIR M.D.		22e. ADDRESS 11700 Old Columbia Pike Silver Spring, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE FEB 9-1985	23c. NAME OF CEMETERY OR CREMATORY KUTZ'S CHURCH CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE MIDDLESEX TOWNSHIP PA
24. FUNERAL DIRECTOR NAME Takoma Funeral Home		25. DATE REC'D. BY REGISTRAR FEB 11 1985	

Female
Orange, 54
A. 2. 24

Trunk size
Wing length
Wing area
Wing area
Wing area

Wing area (same as 182)

X

Wing area (same as 182)

Wing area (same as 182)

Body released to private physician

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Estelle Levin		2a. DATE OF DEATH MONTH DAY YEAR 02/02/85		2b. HOUR M
3 SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 12 02 03		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13e. STREET ADDRESS / ZIP CODE 7114 Fairfax Road 20814	
14. FATHER'S NAME FIRST MIDDLE LAST Lewis Studler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Pearl Axelrad same as #13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Longestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). None				
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) —		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE —		22a. I certify that (1) this hospital attended the deceased from 2/1 , 19 85 , to 2/2 , 19 85 , that (1) (we) lost saw the deceased alive on 2/1 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		
22b. SIGNATURE Raymond Bass		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-2-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond Bass		22e. ADDRESS 3429 Ferrara Wheaton, Md 20906		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 5, 1985	23c. NAME OF CEMETERY OR CREMATORY Sharon Gdns.	
23d. LOCATION CITY OR TOWN COUNTY STATE Valhalla, New York		24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes ADDRESS Falls Church, Va. 22046		
25a. DATE REC'D. BY REGISTRAR FEB 05 1985		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall		

BP

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



DATE

NO.

DESCRIPTION

QUANTITY

UNIT

PRICE

AMOUNT

TOTAL

DATE

BY

INITIALS

REMARKS

REMARKS

2000

REMARKS

REMARKS

REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cotidian papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

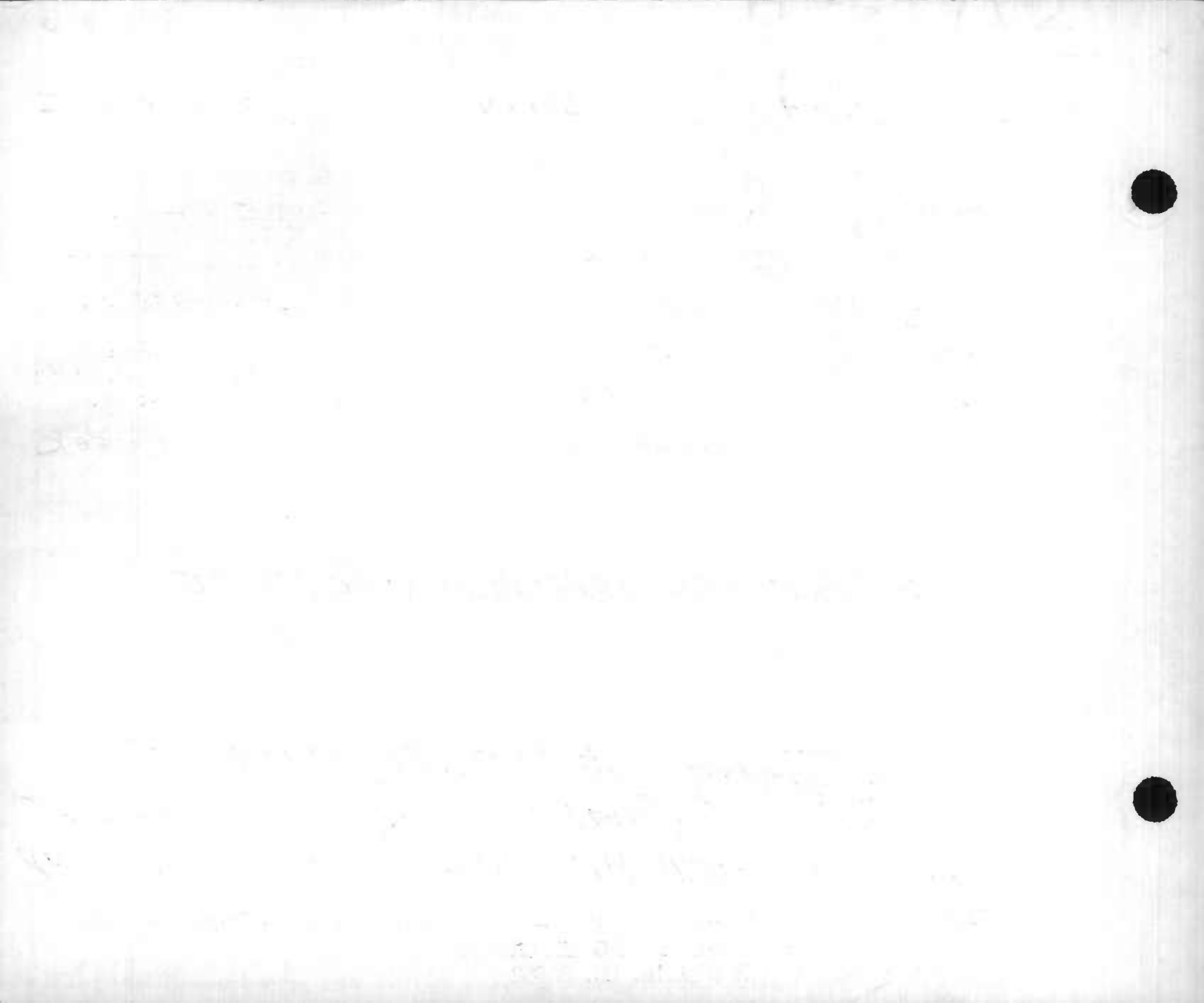
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 9 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LUBA			FIRST MIDDLE LAST LEYIN			2a. DATE OF DEATH MONTH DAY YEAR 2 24 85			2b. HOUR 2:45A^M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 2, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.			7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE New York						13b. COUNTY Kings		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Aaron Brimberg						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Miriam Sokol							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 113-36-9777		17. INFORMANT ADDRESS Rockville, Md. 20852 Theodore Levin; 11806 Hitching Post Lane;					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK			
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (as a physician) attended the deceased from 4 FEB 19 81 to 21 FEB 19 85 , that (I) last saw the deceased alive on 6 FEB 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Walter E. Gooch MD DEGREE										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 21 FEB 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOCH MD					22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/22/85		23c. NAME OF CEMETERY OR CREMATORY Baron Hirsch Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Staten Island, New York					
24. FUNERAL DIRECTOR NAME ADDRESS DAN ZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR FEB 25 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					



Item 4 per phone 2/27/85 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

05694

FOR
1- STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) SYLVIA				FIRST MIDDLE LAST LEWIS				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2 MONTH 15 DAY 1985				2b. HOUR 9:38 PM			
3 SEX FEMALE		4 RACE cau.		5 DATE OF BIRTH MONTH DAY YEAR 5 18 23		6 AGE (IN YEARS) LAST BIRTHDAY 61 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 2-15-1985		2d. HOUR 9:38 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK, MD				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper				12b. KIND OF BUSINESS OR INDUSTRY Bookkeeping			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE MD				13b. CITY OR TOWN MC				13c. CITY OR TOWN SILVER SPRING			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1220 East West Hwy., 20910											
14. FATHER'S NAME FIRST MIDDLE LAST Louis Nadelman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Horowitz											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 105-18-5634				17. INFORMANT Funeral Director - N.Y.				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Richard P. Whelton				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 2-16-85			
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L WHELTON				ADDRESS 2100 Balt Ave College Park MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-17-1985		23c. NAME OF CEMETERY OR CREMATORY United Hebrew Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Staten Island, New York					
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				ADDRESS Rockville, Md.				25a. DATE REC'D. BY REGISTRAR 2-20-1985				25b. REGISTRAR'S SIGNATURE [Signature]			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

100-1-100-1

100-1-100-1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Howard				FIRST Lilly				2a. DATE OF DEATH MONTH 2 DAY 3 YEAR 85				2b. HOUR 8:40 A			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 11 DAY 11 YEAR 06				6. AGE (IN YEARS LAST BIRTHDAY) 78				IF UNDER 1 YEAR MONTHS 78 DAYS 78		IF UNDER 24 HRS HOURS 78 MIN. 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance Exec.				12b. KIND OF BUSINESS OR INDUSTRY Insurance					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST Samuel MIDDLE Lilly LAST Lilly				15. MOTHER'S MAIDEN NAME FIRST Lena MIDDLE Beckerman LAST Beckerman				16. STREET ADDRESS 12000 Old Georgetown Rd., #304S							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 012-05-0381				17. INFORMANT ADDRESS 20854 Mason Lilly; 11050 Seven Hill Lane; Potomac, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour			
DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Infection															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Alzheimer															
19a. DATE OF OPERATION 2/3				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 15				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 2/3							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 2/3				21f. LOCATION STREET 2/3 CITY OR TOWN 2/3 COUNTY 2/3 STATE 2/3							
22a. I certify that (I) (this hospital) attended the deceased from 2/3 19 85 to 2/3 19 85 , that (I) (we) last saw the deceased (above) 2/3 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.															
22b. SIGNATURE Raymond Bass				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/3/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND BASS				22e. ADDRESS 3929 Ferrara Dr Wheaton Md 20906											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/5/85				23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gdns.; Olney; Montgomery; Maryland				23d. LOCATION CITY OR TOWN Olney COUNTY Montgomery STATE Maryland			
24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS NAME 1170 Rockville Pike; Rockville, Md. 20852 ADDRESS 20852															

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Film 601 items 2a & 3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ray Gordon Liphart			2a. DATE OF DEATH MONTH DAY YEAR February 12, 1985			2b. HOUR A 2:54 M					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2800 Blue Spruce Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Contractor		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2800 Blue Spruce Lane 20906		
14. FATHER'S NAME FIRST MIDDLE LAST Ross H. Liphart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Bell Croyle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 172-03-9971			17. INFORMANT ADDRESS Betty R. Liphart Wife Same as 13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Metastatic Prostate Cancer

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHimmediate14YPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-21</u> , 19 <u>84</u> to <u>2-12</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>2-28</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Frederick G. Barr</u> M.D.				DEGREE M.D.		22c. DATE SIGNED 2-13-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick G. Barr, M.D.				22e. ADDRESS 5454 Wisconsin Avenue Bethesda, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Johnstown Cambria Pennsylvania	
24. FUNERAL DIRECTOR NAME Francis J. Collins				25a. DATE REC'D. BY REGISTRAR MAR 4 1985		25b. REGISTRAR'S SIGNATURE <u>Richard Davidson-Randall</u>	
500 University Blvd., W. Silver Spring, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 9 7

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Lillian M. Little</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>2 16 85</u>		2b. HOUR <u>1055 PM</u>
3. SEX <u>Female</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>6 26 15</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>69</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County MD.</u>	
10. CITY OR TOWN OF DEATH <u>Rockville</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>13221 Fox Den Dr.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Secretary</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Board of Education</u>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13b. COUNTY <u>Montgomery</u> 13c. CITY OR TOWN <u>Rockville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>20850 13221 Fox Den Dr.</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Albert Madigan</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Fannie Young</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <u>577 07 7384</u>		17. INFORMANT ADDRESS <u>Luraner M. Summers, same as #13</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Widely metastatic melanoma

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

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19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/29/85</u> , 19 <u>85</u> , to <u>2/16/85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/16/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Arthur F. Woodward Jr</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>2/16/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Arthur F Woodward Jr</u>		22e. ADDRESS <u>Suite 326 18111 Prince Philip Dr. Olney 20832</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>Feb. 20, 1985</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR NAME <u>Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850</u>		25a. DATE REC'D. BY REGISTRAR <u>FEB 21 1985</u>	25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>



100% COTTON
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CHINA



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 6 9 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rose Mary LoBianco			2a. DATE OF DEATH MONTH DAY YEAR 2-6-85		2b. HOUR 6:30 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator Addressograph		12b. KIND OF BUSINESS OR INDUSTRY Mailing & Marketing Co.
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Lanham	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Antonio Arcuri		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Renda			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-18-0521		17. INFORMANT Mr. Nathan LoBianco ADDRESS Address Same as No# 13c.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) metabolic acidosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Diabetes mellitus, disseminated intravascular coagulation					
19a. DATE OF OPERATION 2/4/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal aortic aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/3 , 19 85 , to 2/6 , 19 85 , that (I) (we) last saw the deceased alive on 2/3 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Barry J. Levin, M.D.		DEGREE M.D.		22c. DATE SIGNED 2/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry J. Levin, M.D.		22e. ADDRESS 5410 McKinley St. Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 9, 1985	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A.		ADDRESS Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR FEB 14 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Arthur J Logan					2a. DATE OF DEATH MONTH Feb DAY 6 YEAR 85					2b. HOUR 6:28 A.M.
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH AUG DAY 10 YEAR 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEEL WORKER		12b. KIND OF BUSINESS OR INDUSTRY STEEL		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 4512 STRATHMORE AVENUE 20896			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GARRETT PARK						
14. FATHER'S NAME FIRST JOHN MIDDLE LAST LOGAN				15. MOTHER'S MAIDEN NAME FIRST GERTRUDE MIDDLE LAST HEILMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 170-18-3959		17. INFORMANT PATRICIA L. LOGAN		ADDRESS SAME AS 13		DAUGHTER DAUGHTER		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoxic encephalopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertensive Cardiovascular disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 85 , to 2/6 , 19 85 , that (I) (we) last saw the deceased alive on 2/5 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (I) did not view the body after death.										
22b. SIGNATURE James H. Brodsky MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-6-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James H. Brodsky MD				22e. ADDRESS 4701 Willard Ave Chevy Chase						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/9/85		23c. NAME OF CEMETERY OR CREMATORY GRANDVIEW CEMETERY		23d. LOCATION CITY OR TOWN JOHNSTOWN COUNTY CAMBRIA STATE PA.				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR FEB 11 1985		25b. REGISTRAR'S SIGNATURE [Signature]				

BP

At Home 7 10:00 AM Feb 28 1912

Myocardial infarction
Coronary artery disease
Atherosclerosis
Hypertensive cardiovascular disease

James H. Buckley MD
2-6-1912
2-6-1912

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.					
1- STATE REGISTRAR							8 5 0 5 / 0 0								
1. DECEASED NAME (TYPE OR PRINT) THELMA W. LUCAS							2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR				
3. SEX Fe		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 3 10 19 65		6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 2 17 19 85		2d. HOUR 6:45 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.			
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Analyst				12b. KIND OF BUSINESS OR INDUSTRY Private			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE MD				13b. CITY OR TOWN MONTGOMERY				13c. CITY OR TOWN BETHESDA			
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Wilkes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Boyden				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 20814 4909 ELSMERE AVE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 119-22-0978				17. INFORMANT Joan Manigault				ADDRESS same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DEEP VEIN THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) FRACTURED FOOT												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 3-4 wks 3-4 wks			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION —				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM P.M. JAN 10 1985				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) FELL DOWN STOPS TO BASEMENT							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4909 ELSMERE AVE BETHESDA MONT. MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Francis C. Mayle						TITLE (SPECIFY) Sgt				DATE SIGNED 2-18-85					
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle						MEDICAL EXAMINER				ADDRESS 8200 Wisconsin Ave Bethesda MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 2/19/85		23c. NAME OF CEMETERY OR CREMATORY cedar hill crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD					
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home						4308 Suitland Road Suitland MD				25a. DATE REC'D. BY REGISTRAR FEB 2 1985					
						25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall									

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8505701

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES MICHAEL MARONEY			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 12, 1985		2b. HOUR 6:45A M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 10, 1937		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 47	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas A. Maroney		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Ward		13e. STREET ADDRESS / ZIP CODE 4604 WINSOR LANE 20814			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16b. SOCIAL SECURITY NO. 233-58-7156		17. INFORMANT ADDRESS CHARLESTON, WEST VIRGINIA THOMAS MARONEY (BROTHER) 933 RIDGEMONT RD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Widespread Kaposi's Sarcoma DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 15, 1985 to February 12, 1985 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 12, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE <i>Leonard Biedor</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEONARD BIEDOR, M.D.		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE February 13, 85		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS Metropolitan Funeral Service 5517 Vine Street, Alexandria, Virginia 22310				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 19 1985 Julia Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene after to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) Candida R. Marra					2a. DATE OF DEATH MONTH DAY YEAR 2 11 85		2b. HOUR 1220 PM			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 6, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Gaithersburg					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE #30 County Court/20878			
14. FATHER'S NAME FIRST MIDDLE LAST Jovo Roman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antonia Sanabria					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No			16b. SOCIAL SECURITY NO. 582-56-1372		17. INFORMANT ADDRESS Santiago M. Marra, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HEPATIC ENCEPHALOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(AUTOIMMUNE) CIRRHOSIS, DECOMPENSATED</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 MMEN</u> <u>1 YR</u> <u>5 YRS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>RENAL FAILURE</u>										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 5</u> , 19 <u>85</u> , to <u>FEB 11</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>FEB 10</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Mark Burns</u>				DEGREE MD				ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/11/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK BURNS, MD				22e. ADDRESS 9715 MEDICAL CTR DR #200 ROCKVILLE, MD 20850						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850				25a. DATE REC'D. BY REGISTRAR FEB 14 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 WITHIN 24 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 05703	
1. FOR STATE REGISTRAR											
1. DECEASED NAME [TYPE OR PRINT] ROBERT L MASON										2a. DATE KNOWN OF DEATH MONTH 28 YEAR 1985 HOUR 6:53 AM	
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH Sept. DAY 21 YEAR 1928		6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS.		IF UNDER 1 YR. MONTHS XX DAYS XX HOURS XX MIN.		2c. DATE PRONOUNCED DEAD MONTH February DAY 28 YEAR 1985 HOUR 6:53 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICEMAN		12b. KIND OF BUSINESS OR INDUSTRY D.C.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1001 Gabel Street		20901	
14. FATHER'S NAME FIRST LESLIE MIDDLE I. LAST MASON						15. MOTHER'S MAIDEN NAME FIRST DOROTHY MIDDLE FOSTER LAST FOSTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 578-36-0128		17. INFORMANT ADDRESS MARJORIE B. MASON WIFE SAME AS 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) Yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers M.D.						TITLE (SPECIFY) Dep. MEDICAL EXAMINER		DATE SIGNED Feb 28 1985			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, M.D.						ADDRESS 1919 SEMINARY RD. SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE MAR. 1, 1985		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN ALEXANDRIA COUNTY VIRGINIA STATE			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR MAR 4 1985		25b. REGISTRAR'S SIGNATURE Francis J. Collins			
500 UNIVERSITY BLVD., W. SILVER SPRING, MD.											

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U.S. DEPARTMENT OF HEALTH

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ANNIE LEOLLA MATTARE			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 11 1985		2b. HOUR 2:00 P	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 21 1921		
6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		
12b. KIND OF BUSINESS OR INDUSTRY MOVING COMPANY		13a. STREET ADDRESS / ZIP CODE STAR RT., BOX 132 20619				
13b. STATE MARYLAND		13c. CITY OR TOWN ST. MARY'S		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN WILLIAM BELLAMY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELIA ELIZABETH BROWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-34-6666		17. INFORMANT ADDRESS DOLORES L. SHULTZ, 906 LOUISDALE ROAD, EXXONTON, MD 20619		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 27 19 85 , to FEBRUARY 11 19 85 , that (I) (we) lost saw the deceased alive on FEBRUARY 11 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Dr. E. Woods		DEGREE MD		22c. DATE SIGNED 2/12/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. WOODS, LCDR, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-14-85		23c. NAME OF CEMETERY OR CREMATORY IMMACULATE HEART		
23d. LOCATION CITY OR TOWN COUNTY STATE LEXINGTON PARK ST. MARY'S MD		23e. DATE RECD. BY REGISTRAR FEB 1 9 1985				
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR.		ADDRESS LEONARDTOWN, MD.		25. REGISTRAR'S SIGNATURE <i>John F. ...</i>		

BP

NOTES

DATE



1041

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Russell			MIDDLE Louis			LAST Matthews			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH Feb			DAY 7			YEAR 1985			2b. DATE PRONOUNCED DEAD			MONTH Feb			DAY 7			YEAR 1985		
3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR Sept 15 1967			6. AGE (IN YEARS) (LAST BIRTHDAY) 67 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN			IF UNDER 24 HRS. HOURS MIN			7c. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12c. KIND OF BUSINESS OR INDUSTRY			10. CITY OR TOWN OF DEATH Tate Park			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Advent. Hosp			12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12c. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md			13b. COUNTY Prince Georges			13c. CITY OR TOWN Adelphi			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 20783 Metzerott Rd			14. FATHER'S NAME FIRST MIDDLE LAST Russell LeRoy Matthews			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Huns			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 1944-1951			17. INFORMANT James F. Matthews Son Same as 13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Cardio Pulmonary Dis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS					
19a. DATE OF OPERATION 1-15-85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture L hip			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:00 P.M. 1 11 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Fall out of chair			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET CITY OR TOWN COUNTY STATE Metzerott Rd Adelphi Prince Georges Md														
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			TITLE (SPECIFY) M.D. Dip			MEDICAL EXAMINER			DATE SIGNED Feb 8 1985			ACTUAL SIGNATURE John S. Rogers			EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M. D.			ADDRESS 1919 Seminary Rd. Silver Spring, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 12, 1985			23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia			24. FUNERAL DIRECTOR NAME Francis J. Collins			25a. DATE REC'D. BY REGISTRAR FEB 19 1985			25b. REGISTRAR'S SIGNATURE Lia Davidson-Rendell			500 University Blvd., W. Silver Spring, Md.														

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 / 0 6

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE - MAYO			2a. DATE OF DEATH MONTH DAY YEAR 2 / 13 / 85			2b. HOUR 3:45 PM	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 / 24 / 00		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14364 Chesterfield Road 20853	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Alfred				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Lowry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A				16b. SOCIAL SECURITY NO. 579-07-9196		17. INFORMANT ADDRESS Doris Starling-daughter-(same as 13e)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE DEBILITATION	2 MONTHS
	DUE TO, OR AS A CONSEQUENCE OF (c) DIFFUSE HISTIOCYTIC LYMPHOMA	3 MONTHS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

STAPHYLOCOCCUS AUREUS SEPSIS; CHRONIC LUNG DISEASE

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 12/84 , 19 84 , to 2/13 , 19 85 , that (I) (we) last saw the deceased alive on 2/13 , 19 85 , and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							

22a. SIGNATURE Jules R. Lodish		DEGREE M.D.		22c. DATE SIGNED 2/14/85	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) JULES R. LODISH		22d. ADDRESS 2901 CUNY-SANDY SPRING RD. CLNEY MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial,		23b. DATE Feb. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPT OF COMMERCE

LIBRARY

U.S. DEPT. OF COMMERCE

NO. 100

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>James</u>		FIRST MIDDLE LAST <u>McCANN</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>2-8-85</u>		7b. HOUR <u>4 A</u> M	
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>JULY 19, 1981</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>93</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <u>PENNSYLVANIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery Cty.</u> MD.	
10. CITY OR TOWN OF DEATH <u>GAITHERSBURG</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Wilson Health Care Center</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR INDIVIDUAL WORKING IN INDUSTRY) <u>RET. OWNER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS / ZIP CODE <u>301 RUSSELL AVE. 20877</u>			
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>GAITHERSBURG</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>JAMES McCANN, SR.</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>GRACE SULLIVAN</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>214-28-4162</u>		17. INFORMANT (DAUGHTER) ADDRESS <u>20781 MIRIAM HARDESTY, 1903 RED OAK DR., ADELPHI, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC ADENOCARCINOMA -</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>SOURCE OF ORIGINAL SITE, UNKNOWN</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4</u> <u>3</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>GENERALIZED ARTERIOSCLEROSIS</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 8, 1980</u> to <u>FEB. 8, 1985</u> , that (we) lost saw the deceased alive on <u>FEB. 7, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>John P. Nason, MD</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2-8-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN P. NASON, MD.</u>				22e. ADDRESS <u>800 PERSHING DR. SUITE 105A SILVER SPRING, MD. 20910</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>2/8/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>METROPOLITAN CREMATORY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>ALEXANDRIA, VIRGINIA</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>RICHARD RAPP, INC. 1804 T ST., N.W. WASHINGTON, D.C. 20009</u>				25a. DATE RECD. BY REGISTRAR <u>FEB 13 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Richard Rapp</u>	

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1941
JUL 19 1941
RECEIVED
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.
MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR 1 - STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH		2b. HOUR	
MAE Mae		2-17-85		10:46 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	Feb. 22 1893	91	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Ireland	U.S.A.		MONTGOMERY CO MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	SUBURBAN HOSPITAL		Homemaker		Home
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE		
Maryland	Montgomery	Rockville	11221 Stephalee Lane 20852		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
Michael	Catherine		16b. SOCIAL SECURITY NO.		
	Gillen		579-60-7004		
17. INFORMANT		18. ADDRESS			
Sean F McCarthy.		9108 Kittery Ln., Bethesda, Md.			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Bronchitis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Days</u> <u>Chronic</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/10</u> 19 <u>85</u> to <u>4/17</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>4/17</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Alan N. Schulman</u>		22c. DATE SIGNED <u>4/18/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
Alan N. Schulman, M.D.		9715 Medical Cen. Dr. Rockville, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2/21/1985		Mt. Olivet Cemetery	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016		2/26/85		<u>John K. Randle</u>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		21. HOUR	
Virgil						Mc Cermick		Feb 10		19		85				9:00 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	W	FEB. 22 1927		87		YRS.				Feb 10		19		85			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Missouri		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
St. Louis		Holy Cross Hosp.		BARBER		BARBER											
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Mo		Montg. St. L. Spg.		4508 BENNION RD.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		/20906									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
UNKNOWN		UNKNOWN															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		309-30-1092		CHESTER SMULLIN		SAME AS #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				Acute Myocardial Disi													
				(b) Chronic Myocardial Disi												KRO	
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
None																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
None																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
John S. Rogers		M.D. Dep.		Feb 10 1985													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
JOHN S. ROGERS		SILVER SPRING, MARYLAND															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
BURIAL		FEB/13/85		CEDAR HILL CEMETERY		SUITLAND		P.G. Co.		MARYLAND							
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
CHAMBERS FUNERAL HOME		SILVER SPRING, MD				FEB 13 1985		Julia Davidson-Randall									

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

2. In the second part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

3. In the third part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

4. In the fourth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

5. In the fifth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

6. In the sixth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

7. In the seventh part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

8. In the eighth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

9. In the ninth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

10. In the tenth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

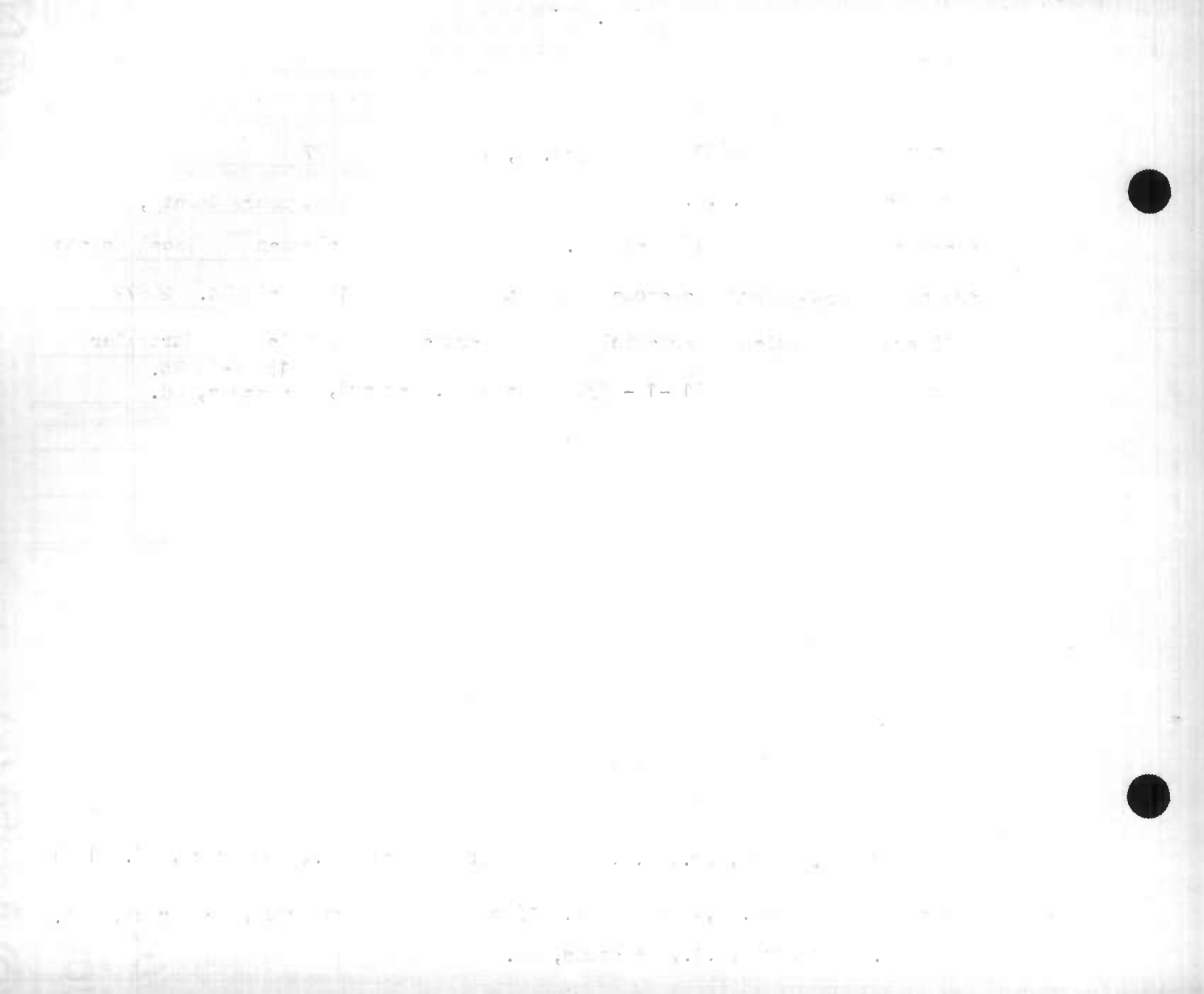


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5 0 5 / 1 0				
1. FOR STATE REGISTRAR				REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) HENRY OAKLEY Mc DANIEL			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 22, 1985			2b. HOUR 4:00AM		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10 CITY OR TOWN OF DEATH Damascus		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9166 Main St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Damascus				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9166 Main St. 20872		
14 FATHER'S NAME FIRST MIDDLE LAST Albert Lucian McDaniel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Eugenia Strickler				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-12-0330		17. INFORMANT ADDRESS Nancy L. Barnard, 9166 Main St. Damascus, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE PROSTATE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 9, 1984 to FEBRUARY 22, 1985 , that (I) (we) last saw the deceased alive on FEBRUARY 3, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE George I. Smith, Jr., M.D.				DEGREE M.D.		22c. DATE SIGNED 22 Feb. 85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George I. Smith, Jr., M.D.				22e. ADDRESS 804 Toll House Ave., Frederick, Md. 21701				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 25, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.		
24. FUNERAL DIRECTOR Ulin L. Molesworth, P.A., ADDRESS Damascus, Md.				25a. DATE REC'D. BY REGISTRAR FEB 27 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Thomas W. McDonald

2a. DATE OF DEATH

MONTH

DAY

YEAR

2/11/85

2b. HOUR

6:05 P.M.

3 SEX

Male

4 RACE

White

5 DATE OF BIRTH

MONTH

DAY

YEAR

5/14/30

6 AGE (IN YEARS LAST BIRTHDAY)

54

IF UNDER 1 YEAR

MONTHS

IF UNDER 24 HRS

DAYS

HOURS

MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

MASS.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD.

10 CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOW IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Engineer

12b. KIND OF BUSINESS OR INDUSTRY

N.A.S.A.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Pr. Geo.

13c. CITY OR TOWN

Lanham

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

6829 Nashville Road 20706

14 FATHER'S NAME

Thomas

MIDDLE

E

LAST

McDonald

15. MOTHER'S MAIDEN NAME

Rose

MIDDLE

Arsenault

LAST

Arsenault

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

025-22-6292

17 INFORMANT

Hope McDonald

ADDRESS

6829 Nashville Rd.

Lanham, Md. 20706

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Terminal Hepatic Failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic Cirrhotic Liver Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

2 months

Many years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (a) (this hospital) attended the deceased from January 29, 1985, to February 11, 1985, that (b) (we) lost
saw the deceased alive on February 11, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above (c) (we) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

James E. Wilson, M.D.

ATTENDING ☒ MEDICAL ☐ STAFF ☐
PHYSICIAN ☒ DIRECTOR ☐ PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

James E. Wilson, Jr. M.D.

11125 Rockville Pike, Ste. 103, Rockville, Md. 20852

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Cremation

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

LEE CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

WASHINGTON

D.C.

24 FUNERAL DIRECTOR

NAME

HALES LANHAM F.H.

9013 ANNAPOLIS RD.

ADDRESS

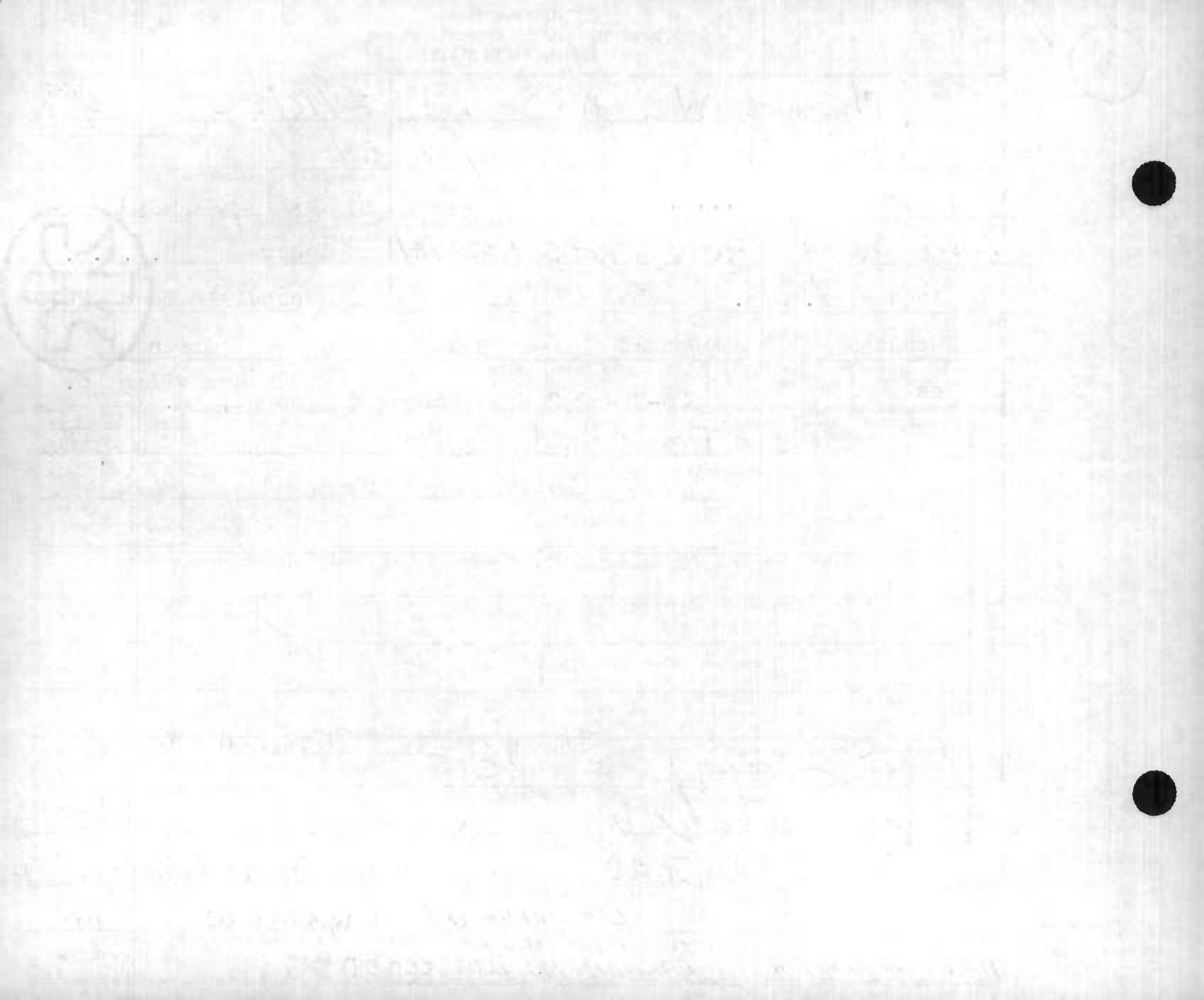
LANHAM, MD. 20706

25a. DATE REC'D. BY REGISTRAR

FEB 20 1985

25b. REGISTRAR'S SIGNATURE

Julie Davidson-Randall



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8505712	
1. DECEASED NAME (TYPE OR PRINT) Marvin W. McFarland										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR Feb 15 1985	
3. SEX M	4. RACE W	5. DATE OF BIRTH (MONTH DAY YEAR) Nov 10 1965	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Feb 20 1985		2d. HOUR 3:32 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Sil. Spg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2217 Shorfield Rd Apt 521				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Science & Technology Cong.		12b. KIND OF BUSINESS OR INDUSTRY Lib.			
USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD	13b. COUNTY Montg	13c. CITY OR TOWN Sil. Spg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2217 Shorfield Rd Apt 521 20902							
14. FATHER'S NAME (FIRST MIDDLE LAST) Wilke McFarland			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Elizabeth Foster			17. INFORMANT Son Ian R. McFarland ADDRESS 7419 Piney Branch Takoma Park, Md. 20912					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 220-48-2732							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dn DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION None											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) MD				DATE SIGNED Feb 25, 1985			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 2, 1985		23c. NAME OF CEMETERY OR CREMATORY Old St. John's				23d. LOCATION CITY OR TOWN COUNTY STATE Forest Glen Montgomery Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins				25a. DATE REC'D. BY REGISTRAR MAR 4 1985				25b. REGISTRAR'S SIGNATURE [Signature]			
500 University Blvd., W. Silver Spring, Md.											

BP



NOTION + PIED

CHAMPAGNE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DANIEL - McGETTIGAN			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 13, 1985			2b. HOUR 11:40 PM			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 30, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY AUTOMOTIVE	
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES MCGETTIGAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE FERRY			17. INFORMANT ADDRESS CATHERINE A. McGETTIGAN SAME AS #13.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE 578-08-8083						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from NOV 73 , 19 73 , to FEB 13 , 19 85 , that (1) (we) lost saw the deceased alive on FEB 13 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Myron L. Kenkin M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED FEB 14, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR MYRON L. KENKIN, M.D.						22e. ADDRESS 2309 SHOREFIELD RD. WHEATON, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE FEB. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY SILVER SPRING, MONT. CO., MARYLAND		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME SILVER SPRING, M.D.			ADDRESS SILVER SPRING, M.D.			25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Agnes Dorothy Mc Glynn			2a DATE OF DEATH MONTH DAY YEAR February 21, 1985			2b HOUR P M 7:05 P M			
1 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR August 28, 1903		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 81		7 UNDER 1 YEAR MONTHS DAYS 81	
12 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Nursing Home			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b KIND OF BUSINESS OR INDUSTRY Own home	
13a STATE Maryland			13b COUNTY P.G.		13c CITY OR TOWN Greenbelt		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Ricardo Wills			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Wills			13e STREET ADDRESS / ZIP CODE 6 K Plateau Place 20770			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 578 10 4998		17 INFORMANT Robert Wills			ADDRESS 20214 Kings Camp Katy, Texas 20214		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic Heart Disease		
DUE TO, OR AS A CONSEQUENCE OF (c) years		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **osteoarthritis**

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from March 19 84 to Feb 21 19 85 , that (I) (we) last saw the deceased alive on Feb 20 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE [Signature]				DEGREE MD		22c DATE SIGNED 2/21/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Raymond T. Benack				22e ADDRESS 4115 Colie Dr. Wheaton, Md. 20906			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 2/23/85		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24 FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home P.A.				25a DATE REC'D. BY REGISTRAR FEB 28 1985		25b REGISTRAR'S SIGNATURE [Signature]	
4739 Baltimore Avenue Hyattsville, Md. 20781							

2025 JUL 10 11 30 AM

MOD. M. T. J. H. A. D.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8505715

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FLORENCE DEMPSEY McGRATH			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 7, 1985			2b. HOUR M	
3. SEX F	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 09 6 31	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		7b. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.				
10. CITY OR TOWN OF DEATH POTOMAC	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11802 ENZO DR. POTOMAC MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME		12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		
13a. STATE MD			13b. COUNTY MONT	13c. CITY OR TOWN POTOMAC	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM DEMPSEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES HASSE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO		16b. SOCIAL SECURITY NO. 577-42-5607		17. INFORMANT ADDRESS FRANCIS X. McGRATH SAME AS 13 HUSBAND			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIO PULMONARY ARREST

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 MIN

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) POORLY DIFFERENTIATED ADENOCARCINOMA
OF THE LUNG

DUE TO, OR AS A CONSEQUENCE OF

(c)

8 MONTHS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

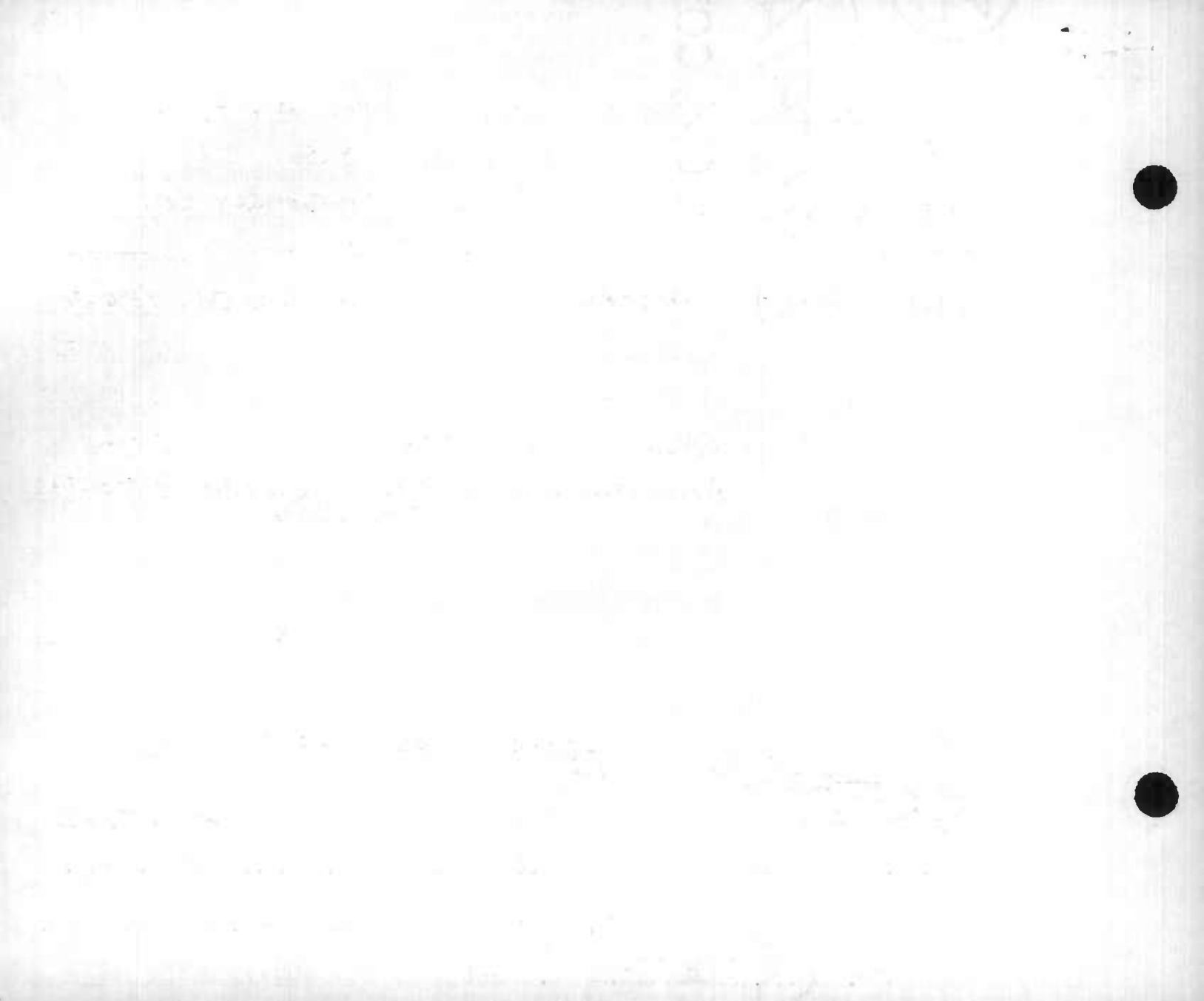
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7 JUNE, 1984, to 7 FEB, 1985, that (I) (we) last saw the deceased alive on 5 FEB, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death.						
22b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. K. WILLIAM HARTER		22c. ADDRESS 3800 RESERVOIR RD., N.W., WASHINGTON, D.C.		22d. DATE SIGNED 2/8/85		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 2/12/85	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR FEB 11 1985	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 85 05716					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT F. McMICAN				2a. DATE OF DEATH MONTH DAY YEAR 2-9-85				2b. HOUR 7:01 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 16 1921		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENN.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.			
10. CITY OR TOWN OF DEATH SS. MARYLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT-RET.		12b. KIND OF BUSINESS OR INDUSTRY FED. GOV'T.	
13a. STATE Md.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4808 LEVADA TERR. 20853	
14. FATHER'S NAME FIRST MIDDLE LAST CLAUDE FRANKLIN McMICAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NINA EDITH HIGGINSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 480-16-0738		17. INFORMANT ADDRESS PEARL V. McMICAN (SAME AS #13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardio-respiratory arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15'	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>central hemorrhage</u>								24h	
(c) <u>Thrombocytopenia ??</u>								48h	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Recent aortic valve Replacement & Cor. Bypass Surgery</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/1/85</u> to <u>2/9/85</u> , that (I) (we) lost saw the deceased alive on <u>2/9/85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen Jones</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/10/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Jones Md.				22e. ADDRESS 809 Viers Mill Rd Rockville 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE FEB 16/1985		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PCC. Md.			
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS Co INC				ADDRESS SILVER SPRING MD		25a. DATE REC'D BY REGISTRAR FEB 15 1985			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

COMMON FIBER



MADE IN U.S.A.

25000 100000 150000 200000 250000 300000 350000 400000 450000 500000 550000 600000 650000 700000 750000 800000 850000 900000 950000 1000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lee J. McMinn			2a. DATE OF DEATH MONTH DAY YEAR February 20, 1985			2b. HOUR DAY MIN. 7:52 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 14 09		6. AGE (IN YEARS LAST BIRTHDAY) 76		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired supervisor/direct mail		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 13526 Oriental Street 20853									
14. FATHER'S NAME FIRST MIDDLE LAST Leroy A. Judge			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Elizabeth Johnson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 125-03-9640		17. INFORMANT ADDRESS J. McMinn Corsini same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE								Syn	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CARCINOMA of BLADDER, METASTATIC									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/1 , 19 84 , to 2/20 , 19 85 , that (I) (we) lost saw the deceased alive on 1/3 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Carl I. Schoenberger						DEGREE MD		22c. DATE SIGNED 2/20/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl I. Schoenberger						22e. ADDRESS 16 220 Frederick Rd Catonsville			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 2/21/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION Suitland, Maryland STATE		
24. FUNERAL DIRECTOR Fyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR FEB 25 1985		25b. REGISTRAR'S SIGNATURE J. Davidson	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 8 is marked, any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Luella B. McNay				2a. DATE OF DEATH MONTH DAY YEAR February 12, 1985				2b. HOUR 12:00A			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 28, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grants Ass't. U.S. Gov't.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10523 Montrose Ave. 20814	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Morris Baily				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernice Cleavenger							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 202 12 6822		17. INFORMANT ADDRESS Earl C. McNay Son same as 13e							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE STREET							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> 19 <u>85</u> to <u>2/12</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/11</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Mark F. Weinstein MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Feb. 12, 1985			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark F. Weinstein, M.D.				22e. ADDRESS 11125 Rockville Pike Rockville, Md. 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 15, 1985		23c. NAME OF CEMETERY OR CREMATORY Greene Co. Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Greene Co., Pa.					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE [Signature]					

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RECEIVED

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BOX COLTON PILES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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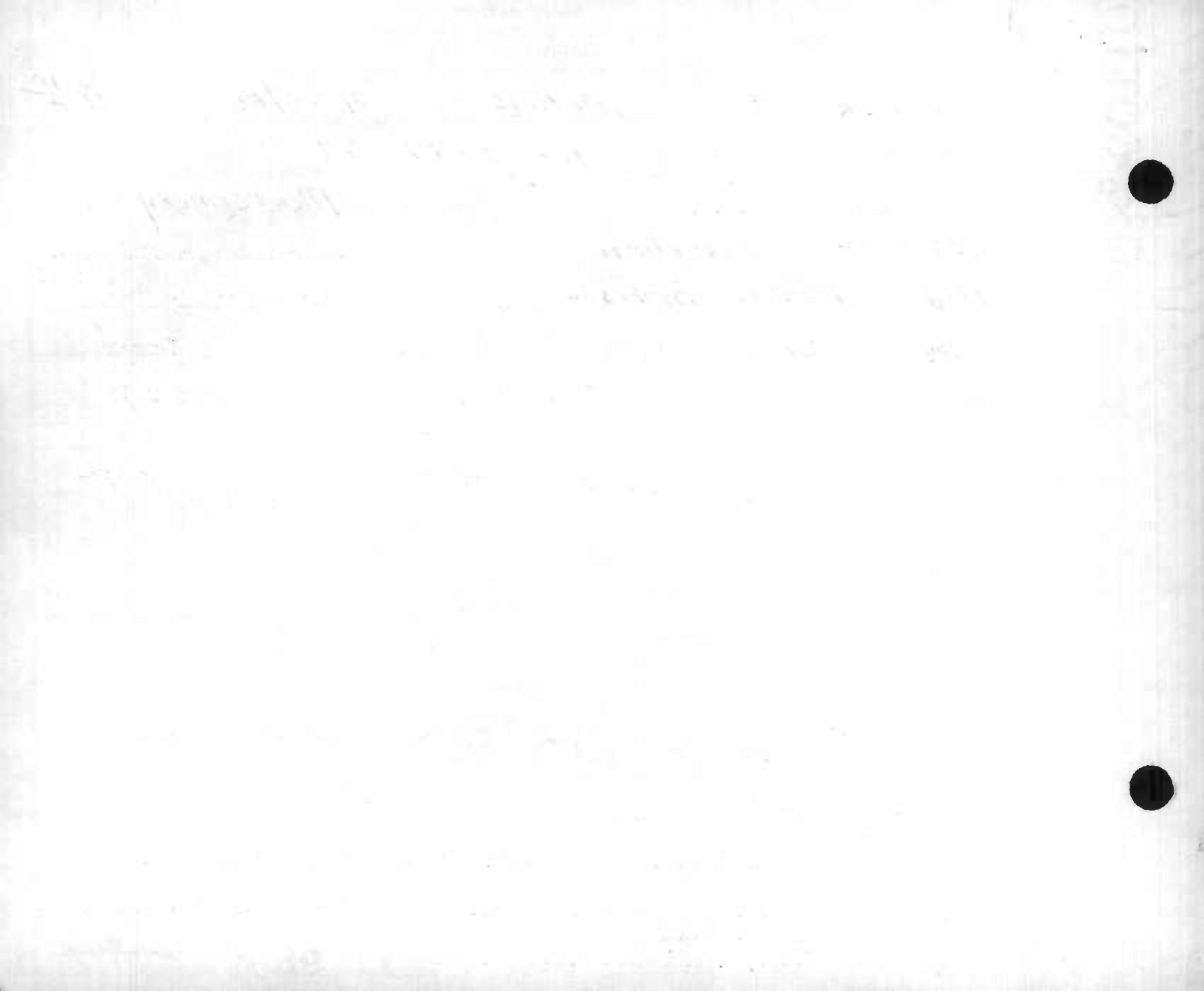
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GOMER T. McNEIL			2a. DATE OF DEATH MONTH DAY YEAR 2/23/85		2b. HOUR 10 MIN. 11 A M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11-27-17		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 67		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer-Photogrammetric Eng.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY MONTG.		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Roy Leslie McNeil			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Thoman			13e. STREET ADDRESS / ZIP CODE 10252 Hatherleigh Drive 20814		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 173-05-8364		17. INFORMANT Myrtie Mae McNeil Wife Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) Brain tumor DUE TO, OR AS A CONSEQUENCE OF (c) 8 yr APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) did (we) hospital attended the deceased from Feb 23 19 85 to Feb 23 19 85 , that (I) (we) last saw the deceased alive on Feb 23 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE W. K. Fitzgerald M.D.				DEGREE MD		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, M.D.				22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md. 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 26, 1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		
24. FUNERAL DIRECTOR NAME Francis J. Collins				25a. DATE REC'D. BY REGISTRAR				
500 University Blvd., W. Silver Spring, Md.				25b. REGISTRAR'S SIGNATURE John Burdick-Rodriguez				

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed - page 2 has an address with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical director of the State Department of Health and Mental Hygiene should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 5 7 2 0	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FAITH Marie MELIA						2a. DATE OF DEATH MONTH DAY YEAR Feb. 03 1985		2b. HOUR M 6:26 A			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR AUG. 20th 1940		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? MONTGOMERY/USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, BALTIMORE COUNTY, OR MONTGOMERY COUNTY) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Anne Arundel Laurel						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3348 /Wye Mills So. 20707			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph H. Melia				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma D. Watkins				16. ADDRESS 20906			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-76-6513		17. INFORMANT ADDRESS Mary K. Main 3322 May St. Silver Spring, Md. 20906							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Hx of Congestive Heart Failure</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/3</u> , 19 <u>85</u> , to <u>2/3</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/3</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>W. Mervia</u>				DEGREE M.D.				22c. DATE SIGNED 2/3/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. MERVIA				22e. ADDRESS 2201 Wisconsin Ave N.W. WASH D.C 20007							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb. 5, 1985		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia					
24. FUNERAL DIRECTOR NAME Francis J. Collins				500 University Blvd. West Silver Spring, Maryland 20901		25a. DATE REC'D. BY REGISTRAR FEB 7 1985		25b. REGISTRAR'S SIGNATURE Davidson-Randall			

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10/10/10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "other," the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

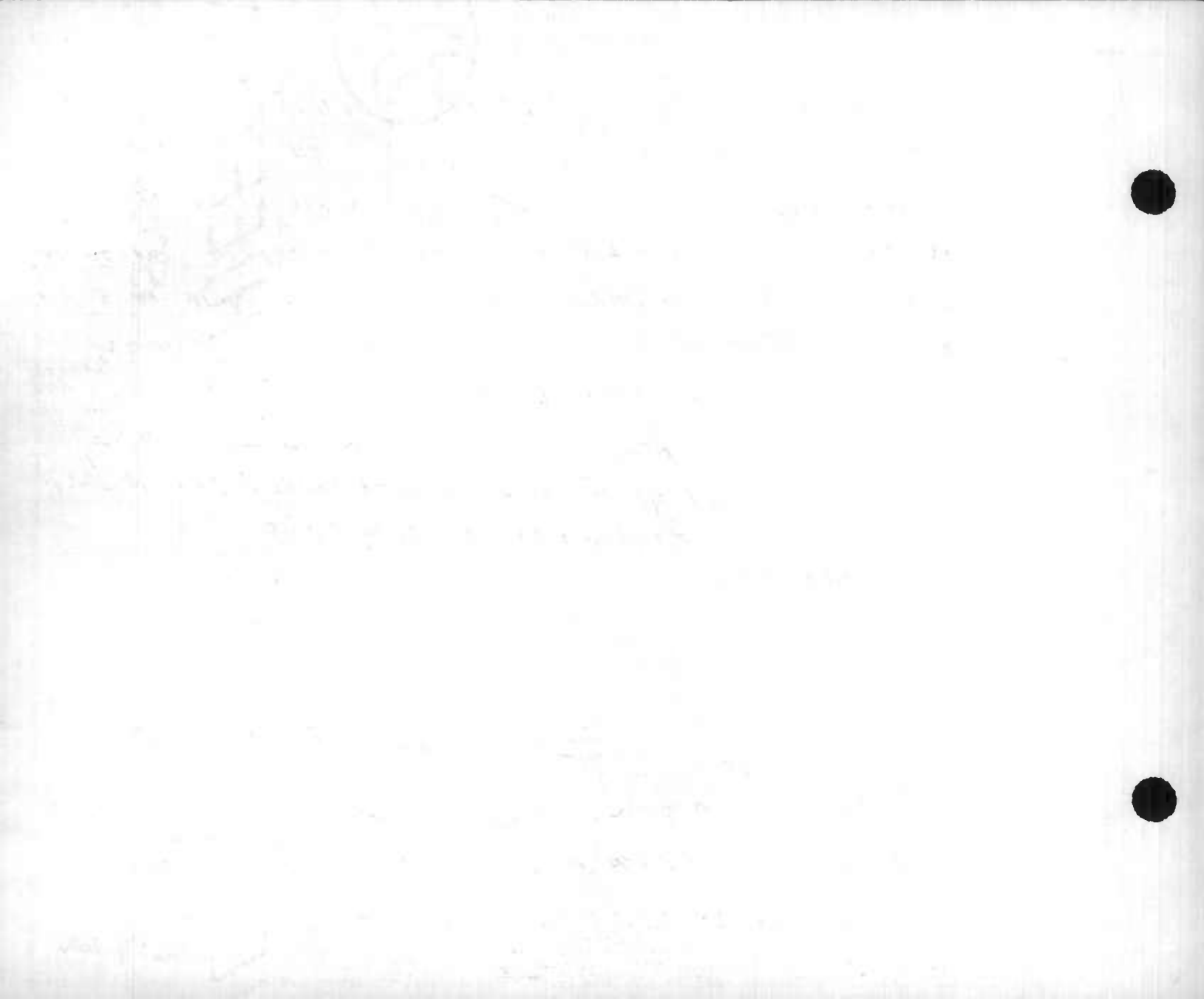
8505721

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA NAH MELLER			2a. DATE OF DEATH MONTH DAY YEAR 2/7/85			2b. HOUR 2 P M			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 12 30 1898		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIENNA, AUSTRIA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 402, 18700 WALKER CHOICE ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRESSMAKER		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.		13b. COUNTY MONT		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 18700 WALKER CHOICE ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST IGNAZ HECHT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EUGENIA SQUARZ					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 062-24-9130		17. INFORMANT ADDRESS LUTH TAFT - 19615 ENTERPRISEWAY GAITHERSBURG			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cerebrovascular accident.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive cardiovascular disease								10 years	
(c) Generalized arteriosclerosis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Old C.O.A.									
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Feb 5 , 19 85 , to Feb 7 , 19 85 , that (I) (we) last saw the deceased alive on 2/6 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Luigi Cosca			DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 2/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIGI C. COSCA, MD			22e. ADDRESS 17221 REDLAND ROAD GAITHERSBURG MD, 20855						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb 11, 1985		23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Gd ns. Olney, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike			24. FUNERAL DIRECTOR ADDRESS Rockville, Md.		25a. DATE REC'D. BY REGISTRAR FEB 13 1985				

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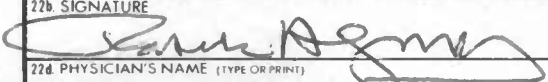
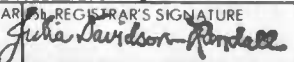


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) George Brent Mickum, III			2a. DATE OF DEATH MONTH DAY YEAR February 26, 1985			2b. HOUR 5:35A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 13 1928		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 44 Grafton Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney			12b. KIND OF BUSINESS OR INDUSTRY Stepcoe & Johnson	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Brent Mickum Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mae Love			13e. STREET ADDRESS / ZIP CODE 44 Grafton St., 20815			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT George Brent Mickum IV, 1402-28th St., N.W.		ADDRESS: Wash., D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma head, neck, primary Unknown DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION 9/6/1984		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cervical Carcinoma			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 9 , 19 84 , to Feb. 26 , 19 85 , that (I) (we) lost saw the deceased alive on Feb. 25 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/26/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Coyne, M.D.		22e. 1145 19th Street, N.W., Suite 204 Washington, D.C. 20036							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/27/1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland		
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc.		ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.		25. DATE REC'D. BY REGISTRAR MAR 1 1985		25. REGISTRAR'S SIGNATURE 			

BP _____

Director, FBI

4321312

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 7 2 3

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LLOYD MILES.			2a. DATE OF DEATH MONTH 2 DAY 13 YEAR 85			2b. HOUR 11:35 P.M.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH September DAY 14 YEAR 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont MD.			
10. CITY OR TOWN OF DEATH Maryland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sub Contractor		12b. KIND OF BUSINESS OR INDUSTRY Unknown	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Takoma		13c. CITY OR TOWN Takoma		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8502 16th St., Silver Spring, Md.	
14. FATHER'S NAME FIRST William MIDDLE LAST Miles				15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE Thomas LAST 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-03-0793		17. INFORMANT ADDRESS Mrs. Mattie Miles/wife/same as 9d			

18. CAUSE OF DEATH (Enter only one cause prevailing for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

Cardiorespiratory arrest
Massive Cerebral infarct
Subcl. cardiac arrhythmia.

DUE TO, OR AS A CONSEQUENCE OF

Severe hypertension. Atherosclerosis.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

Severe hypertension. Atherosclerosis.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS (INHERENT ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)

21d. INJURY OCCURRED

AT HOME ☐ NOT AT HOME ☐
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22. I certify that (I) (this hospital) attended the deceased from **2/13/85** to **2/13/85**, that (I) (we) last saw the deceased alive on **2/13/85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE

DEGREE

22c. DATE SIGNED

Miguel A. Rodriguez

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Miguel A. Rodriguez

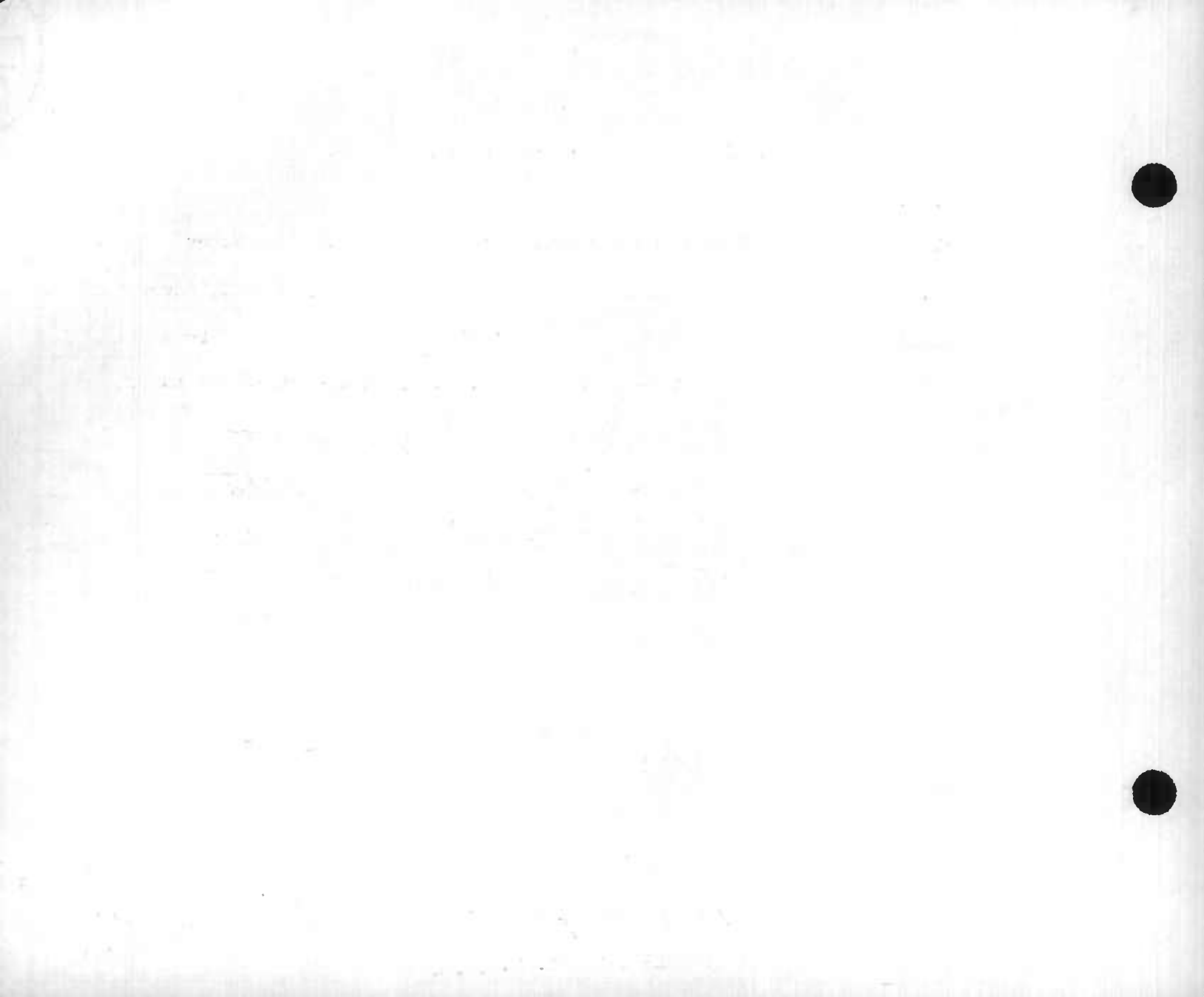
831 University Blvd. S. Spring, Md.

23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 2-19-85		23c. NAME OF CEMETERY OR CREMATORY MARYLAND NATIONAL		23d. LOCATION CITY OR TOWN LAUREL COUNTY MD. STATE 	
24. FUNERAL DIRECTOR Blaine F. Home ADDRESS 3015 12th St. N.E.D.C.				25a. DATE REC'D. BY REGISTRAR 180 1005		25b. REGISTRAR'S SIGNATURE Davidson-Rendell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLOTTE ELIZABETH MILLER			2a. DATE OF DEATH MONTH DAY YEAR FEB 07 1985		2b. HOUR 12:30 pm	
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MARCH 05 1912		
6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD.				
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		
12b KIND OF BUSINESS OR INDUSTRY Home		13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13b STREET ADDRESS / ZIP CODE 4524 South CHELSEA LANE 20814		13c CITY OR TOWN BETHESDA				
14 FATHER'S NAME FIRST MIDDLE LAST CHARLES ERNEST SLOMKE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNA NMN ADLIFF				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-38-8992		17 INFORMANT ADDRESS 4524 South CHELSEA LANE THOMAS JAMES MILLER BETHESDA, NM MD 20814		
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 04 FEBRUARY 1985 , to 07 FEBRUARY 1985 , that (I) (we) lost saw the deceased alive on 07 FEBRUARY 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <i>J. B. Hermiller</i>		DEGREE MD		22c DATE SIGNED 8 FEB 85		
22e PHYSICIAN'S NAME (TYPE OR PRINT) J. B. HERMILLER, LT, MC, USNR		22e ADDRESS NAVAL HOSPITAL, BETHESDA, MD 20814-5011				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Feb. 11, 1985		23c NAME OF CEMETERY OR CREMATORY Arlington National		
23d LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia		24 FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND		25a DATE REC'D. BY REGISTRAR FEB 14 1985		
25b REGISTRAR'S SIGNATURE <i>J. B. Davidson</i>						

BP

30% COLTON FIBER

WIND M. W. A. H. A. D.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1- FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) Jessica Miller										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2/ 16/ 19 85			
3. SEX Female 4. RACE White 5. DATE OF BIRTH Nov. 11, 1984 6. AGE (IN YEARS) 3 7. IF UNDER 24 HRS. 5 8. DATE PRONOUNCED DEAD 2/ 16/ 19 85										2b. HOUR 11:30			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.													
10. CITY OR TOWN OF DEATH Rockville 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A 12b. KIND OF BUSINESS OR INDUSTRY N/A													
13a. STATE New Jersey 13b. COUNTY Ocean 13c. CITY OR TOWN Bricktown 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 13e. STREET ADDRESS 572 New Jersey Avenue (08724)													
14. FATHER'S NAME Martin Miller 15. MOTHER'S MAIDEN NAME Ellen Bluestein													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) ----- 16b. SOCIAL SECURITY NO. None 17. INFORMANT Bricktown, N.J. 08724													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 2/19/85			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 2/20/85 23c. NAME OF CEMETERY OR CREMATORY New Montefiore Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Farmingdale; L.I.; New York													
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852 DATE REC'D. BY REGISTRAR Feb 22, 1985 25b. REGISTRAR'S SIGNATURE Jule Davidson-Rondella													



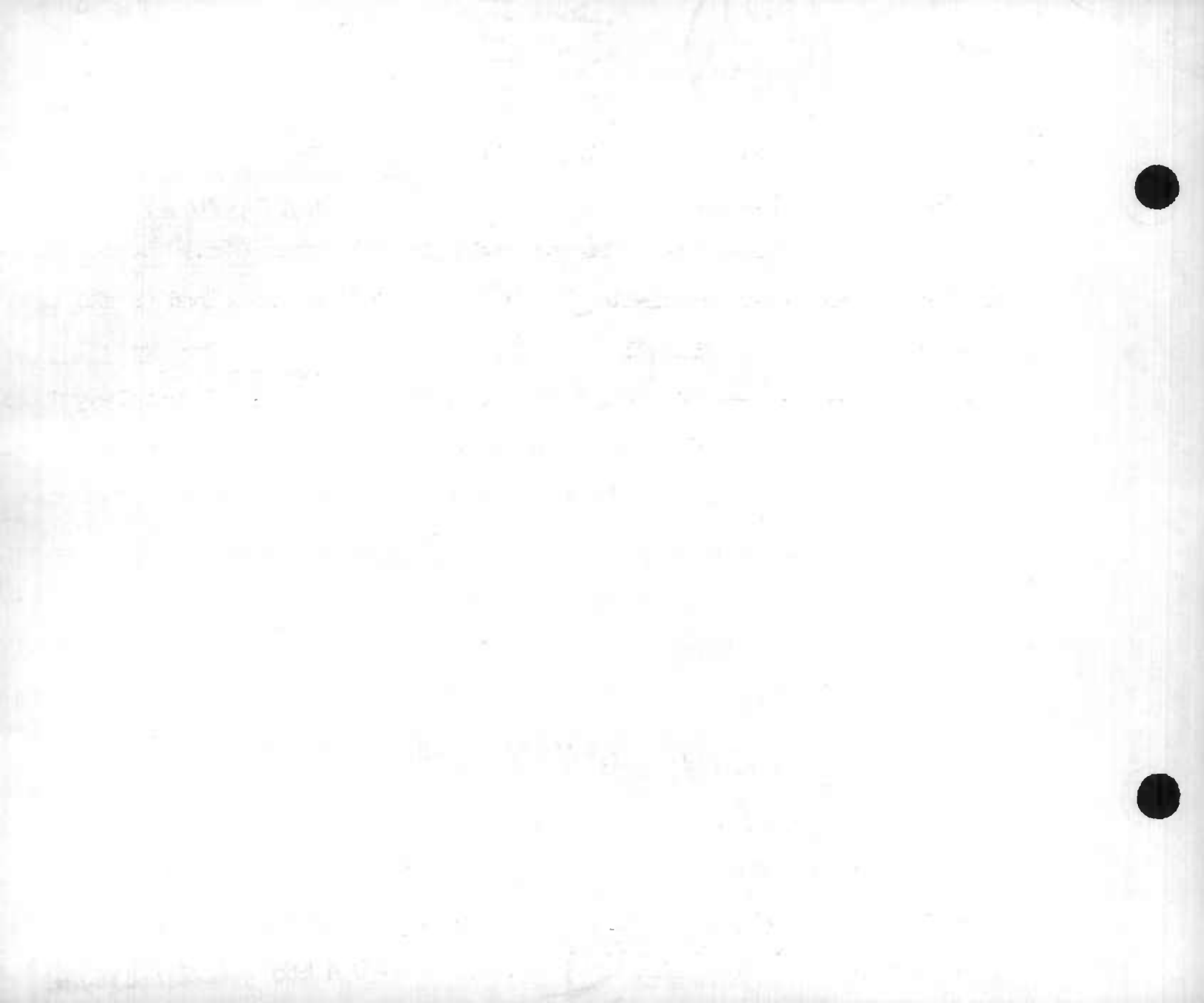
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7. REG. NO. 05726					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUIS MITCHELL					2a. DATE OF DEATH MONTH DAY YEAR 02 01 85			2b. HOUR 7:30 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 17, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cab Driver (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY Diamond Cab Co		
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Israel Mitchell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dona Bransky					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-22-2150		17. INFORMANT ADDRESS Maryland 20815 Robert E. Lynch; 4802 Leland Street; Chevy Chase			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>—</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>07/23/81</u> , 19 <u>81</u> to <u>02/01/85</u> , that (I) (we) last saw the deceased alive on <u>02/01/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>D.D. Patel</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 02/01/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.D. PATEL			22e. ADDRESS 6121 MONTROSE RD, ROCKVILLE, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/4/85		23c. NAME OF CEMETERY OR CREMATORY Adas Israel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Maryland 20852					25a. DATE REC'D. BY REGISTRAR FEB 04 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT MOIEN				MONTH DAY YEAR HOUR 2 15 85 12³⁰ P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 4 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Hebrew Home of Greater Washington		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Butcher		12b. KIND OF BUSINESS OR INDUSTRY Meats	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Yudel Moien				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Kurland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-10-9019		17. INFORMANT ADDRESS Eunice Stearman (Same as # 13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Stroke							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —			
22a. I certify that (1) (this hospital) attended the deceased from 3/11 19 85 , to 2/15 19 85 , that (1) (we) lost saw the deceased alive on 2/15 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE Raymond Bass				DEGREE MD		22c. DATE SIGNED 2-15-85	
22d. PHYSICIAN NAME (TYPE OR PRINT) RAYMOND BASS				22e. ADDRESS 3429 Fessenden Dr. Wheaton, Md 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/17/1985		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION Falls Church, COUNTY Virginia	
24. FUNERAL DIRECTOR DONALD H. STEIN HEBREW MEMORIAL FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR FEB 21 1985		25b. REGISTRAR'S SIGNATURE Jane Davidson-Randall	
24. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.							



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ESTHER MOORE			2a. DATE OF DEATH MONTH DAY YEAR 2 27 85			2b. HOUR 8:45 P.M.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 30 1921		6. AGE (IN YEARS LAST BIRTHDAY) 63		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE N.J.		13b. COUNTY Monmouth		13c. CITY OR TOWN Asbury Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10000 3rd Ave. 09912	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN HORAH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FREDERICKA McRAE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 158-14-3441		17. INFORMANT ADDRESS Debra Russell (Daughter) 9120 Tulip Grove Gath. Md. 20879					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Thr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) ventricular arrhythmias	
		(c) cardiac artery disease	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

Cardiomyopathy

19a. DATE OF OPERATION 9/9/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 13-15 E. Dean Park, G'burg Md			
22a. I certify that (I) (this hospital) attended the deceased from 2/27 , 19 85 , to 2/27 , 19 85 , that (I) (we) last saw the deceased alive on 2/27 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dennis R. Rigney				DEGREE MD		22c. DATE SIGNED 2/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis Rigney				22e. ADDRESS 13-15 E. Dean Park, G'burg Md			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Removal		23b. DATE 3-2-85		23c. NAME OF CEMETERY OR CREMATORY Jackson Funeral Home		23d. LOCATION CITY OR TOWN COUNTY STATE Neptune Monmouth, N.J	
24. FUNERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Wash. St. Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR MAR 04 1985	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DATE

RECEIVED

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PAID TO THE ORDER OF

THE BANK OF AMERICA

FOR THE SUM OF

ONE HUNDRED DOLLARS

AND NO/100

FOR THE PAYMENT OF

THE ACCOUNT OF

THE BANK OF AMERICA

TO THE ORDER OF

THE BANK OF AMERICA

FOR THE SUM OF

ONE HUNDRED DOLLARS

AND NO/100

FOR THE PAYMENT OF

THE ACCOUNT OF

THE BANK OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, the medical examiner must be notified through the medical examiner.

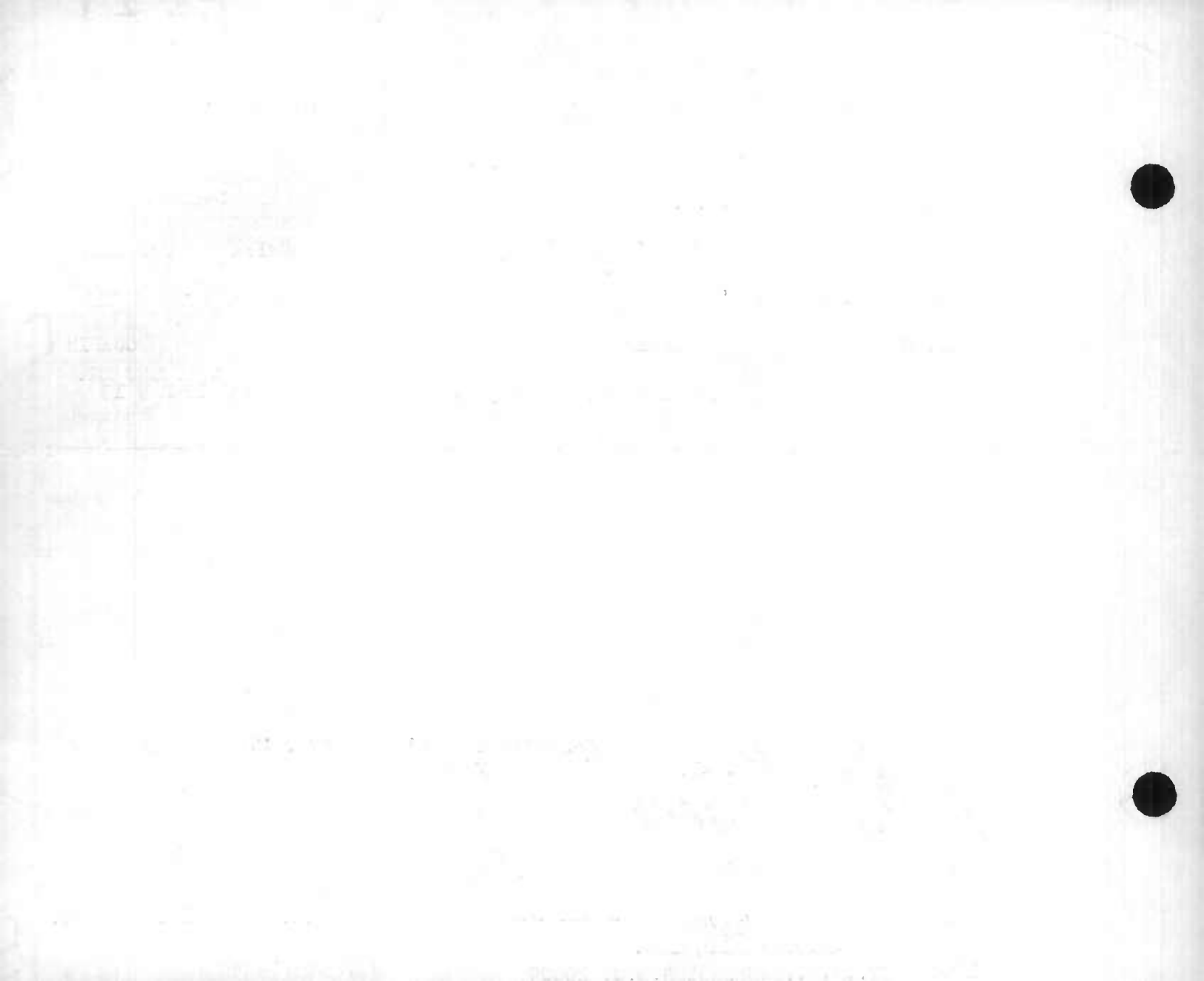
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		FEBRUARY 15, 1985		3:05 ^a _m	
JEAN		MARIE		MOREAU							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS	
FEMALE		WHITE		MARCH 14, 1958		26 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MAINE		U.S.A.				MONTGOMERY COUNTY,				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA		CLINICAL CENTER (NIH)		HOUSEWIFE		OWN HOME					
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE					
MARYLAND		PRINCE GEO'S		YES <input type="checkbox"/> NO <input type="checkbox"/>		4768 CLEVELAND LN 20335					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
ALPHY		GODIN		AUORE		CORBIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		005-60-9711		MR. PAUL MOREAU (HUSBAND)		SAME AS ABOVE				ITEM # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)		Hodgkin's Disease									
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)									
DUE TO, OR AS A CONSEQUENCE OF		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (X) (this hospital) attended the deceased from December 2, 1981, to FEB. 15, 1985, that (X) (we) last saw the deceased alive on FEB. 15, 1985, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. ADDRESS		22d. DATE SIGNED					
Rudolph E Willis				NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205		2/15/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Rudolph E Willis											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
CREMATION		2/15/85		CEDAR HILL CREMATORY		SUITLAND		PG.		MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
RICHARD RAPP, INC.		FEB 20 1985									
1804 T ST., N.W., WASHINGTON, D.C. 20009											

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

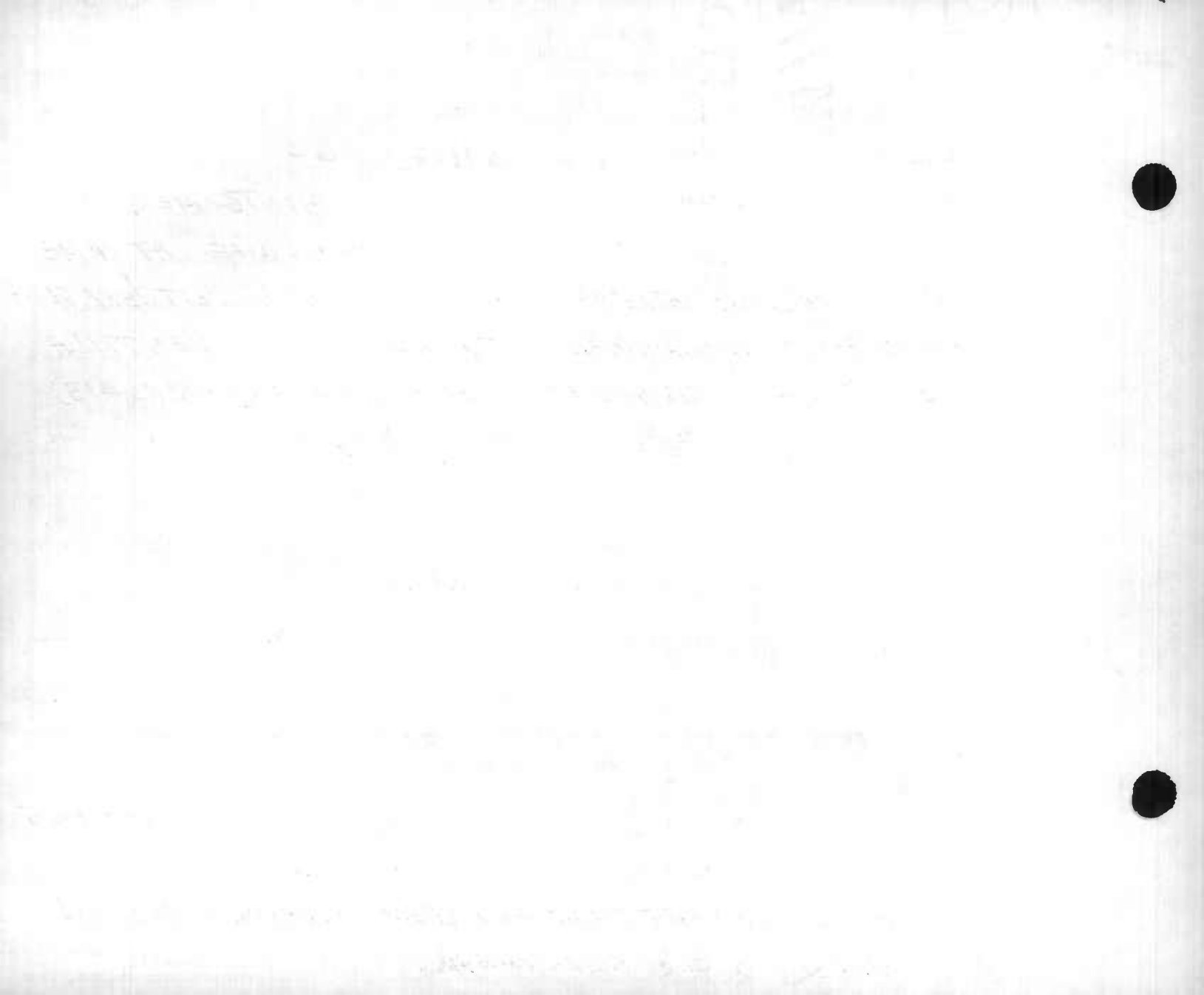
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 05730			
1. DECEASED NAME (TYPE OR PRINT) Sisko R. Morehouse										2a. DATE OF DEATH MONTH DAY YEAR 2/8/85		2b. HOUR 225 AM	
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 13 1922			6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FINLAND			7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.					
10. CITY OR TOWN OF DEATH Bethesda, MD.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5705 WICKETT TERR. 20814				
14. FATHER'S NAME FIRST MIDDLE LAST KAARLO EEINO SAASTAMONEN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TYNNE PENTILLA								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-64-0027		17. INFORMANT ADDRESS WILLIAM A MOREHOUSE (SAME HS #13)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of the Lung										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month			
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic Obstructive Lung Disease													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/5 19 85 to 2/7 19 85 , that (I) (we) last saw the deceased alive on 2/7 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert H Blee MD						DEGREE MD			22c. DATE SIGNED 2-8-1985				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert H Blee MD						22e. ADDRESS 8218 Wisconsin Ave, #414							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE FEB 9, 1985		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREM.			23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PGC MD.					
24. FUNERAL DIRECTOR NAME ADDRESS WW CHAMBERS Co. Inc SILVER SPRING, MD						25a. DATE REC'D. BY REGISTRAR FEB 13 1985							
						25b. REGISTRAR'S SIGNATURE John Davidson-Randall							

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										05731 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) JOY Ann Farnsworth MORGAN						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 2-3-85		2b. HOUR 19		2c. DATE PRONOUNCED DEAD 2-3-85		2d. HOUR 6:50A			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Feb. 17, 1957		6. AGE (IN YEARS) 28 YRS.		7. IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Trenton, Michigan				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				10. CITY OR TOWN OF DEATH Takoma				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurses Aide				12b. KIND OF BUSINESS OR INDUSTRY Institutional				13a. STATE Virginia				13b. COUNTY Prince William			
13c. CITY OR TOWN Woodbridge				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 13227 Nickleson Drive				14. FATHER'S NAME Clair E. Fairnsworth			
15. MOTHER'S MAIDEN NAME Roberta Richards				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 384-68-4516				17. INFORMANT Mrs. Norine Costanzo			
17. ADDRESS 13227 Nickleson				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Narcotism				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) Dr. Woodbridge, VA 22193				DUE TO, OR AS A CONSEQUENCE OF (b) _____				DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Margarete A. Korell				TITLE (SPECIFY) Assistant				DATE SIGNED 2-4-85							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Feb. 7, 1985				23c. NAME OF CEMETERY OR CREMATORY Lee Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Cunningham-Mountcastle Funeral				25a. DATE REC'D. BY REGISTRAR FEB 11 1985				25b. REGISTRAR'S SIGNATURE John Davidson-Randall							
3318 Ococoan Road				Woodbridge, VA 22191											

THIRTY-THREE

1938

March 2nd

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		2b. HOUR	
Thomas Skillman MORRIS		2 8 85		9.00 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MALE	Caucasian	March 22, 1897	87	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.	United States		Montgomery County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Rockville	Potomac Valley Nursing Home		Foreman of Laborers		U.S. Civil Service
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
13a. STATE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	7616 Massena Road Zip: 20817		
13b. COUNTY					
Maryland					
13c. CITY OR TOWN					
Montgomery					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Thomas Morris		Catherine Whitely			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) ADDRESS	
No		578-52-8116		7616 Massena Road Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Cardio-vascular arrest				15'	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Cerebral Infarction		24h	
		(c) Cerebral Thromboembolism		10-12	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
1) Bronchitis 2) Dehydration 3) Organic Brain Syndrome					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/26/83 to 2/7/85, that (I) (we) last saw the deceased alive on 2/7/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Stephen Jones, M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
		809 Viers Mill Road, Rockville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	1985 February 11,	Mt Olivet Cemetery	Washington, D.C.		
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Avenue, Bethesda, Maryland	FEB 14 1985				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 05733								
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR
David M. Moses					Feb. 8, 1985					10:20P _M
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Male		Caucasian		June 2, 1924		60 YRS.		MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Michigan		U.S.A.				Montgomery County, MD				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Potomac		7921 Ivymount Terrace				Metallurgical Eng. Nat. Sys Mgt.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a STATE			13b COUNTY			13c CITY OR TOWN	
			Maryland			Mont.			Potomac	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d INSIDE CITY LIMITS?				
William B. Moses			Dorothy Ackerman			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS				
Yes			WWII/Korea			Bernice Moses 7921 Ivymount Ter. Potomac, MD				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Cancer - Primary Kidney</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
Jay A. Ocuin, MD								2/9/85		
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS							
Jay A. Ocuin			3301 New Mexico Ave NW, Washington, DC 20016							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			02/11/85		Forest Lawn Cem.		Norfolk, VA			
24 FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE							
Ives-Pearson F.H., 472 N Wash., Falls Church, VA			FEB 15 1985 J. A. Davidson							

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 05734	
1. DECEASED NAME (TYPE OR PRINT) Katherine L. Mullally			2a. DATE OF DEATH MONTH DAY YEAR Feb 22 1985		2b. HOUR 5 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 17 63	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Garden Nursing CTR		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.	13b. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS / ZIP CODE 4801 Connecticut Ave., N.W. 20008		
14. FATHER'S NAME FIRST MIDDLE LAST John Long	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret O'Keefe				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 577-54-2046	17. INFORMANT ADDRESS James A. Mullally, 1409 Stagner, Carlshad, N.M.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse DUE TO, OR AS A CONSEQUENCE OF (b) Ovarian Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Dementia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days '83 Years Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that WR this hospital attended the deceased from 12/24 , 19 84 , to 2/22 , 19 85 , that (I) (we) last saw the deceased alive on 2/22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ylene P. Larsen MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/22/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) YLENE LARSEN MD		22e. ADDRESS 1234 19th St NW DC 20036			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/26/1985	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.					

FEB 28 1985

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

05735

1. FOR STATE REGISTRAR		20. DATE OF DEATH		21. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		20. DATE OF DEATH		21. HOUR	
MYRTLE LYNNE MULLER		FEBRUARY 21 1985		12:39 AM	
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
FEMALE	CAUCASIAN	FEBRUARY 13 1914	71 YRS.	IF UNDER 72 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
ILLINOIS	UNITED STATES		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL		HOUSEWIFE		
13a. STATE		13b. CITY OR TOWN	13c. STREET ADDRESS / ZIP CODE		
VIRGINIA	FAIRFAX	SPRINGFIELD	8201 SMITHFIELD AVENUE 22152		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
CHARLES LYNNE		MABEL NELSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		322-01-7880		ROBERT E. MULLER, 8201 SMITHFIELD AVENUE, SPRINGFIELD, VA 22152	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY FAILURE</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) <u>WIDELY METASTATIC ADENOCARCINOMA</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 16, 1985</u> , to <u>FEBRUARY 21, 1985</u> , that (I) (we) last saw the deceased alive on <u>FEBRUARY 21, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		MD		22 FEB 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
D. L. GRIFFEN III, LT. MC, IJSNR		NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
CREMATION		2/23/85		LEE'S CREMATORY	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VIRGINIA					

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DR ROGERS NOTIFIED OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18, show any injury, or other traumatic event, the medical examiner must be notified of the event.

DHMH - 16 60M 7/84
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

05736

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH P. MURPHY			2a DATE OF DEATH MONTH DAY YEAR 02 20 1985		2b HOUR 3:14P M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 08 10 1908	6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. POLICEMAN	12b KIND OF BUSINESS OR INDUSTRY D.C. POLICE	
13a STATE MARYLAND			13b COUNTY MONTGOMERY	13c CITY OR TOWN WHEATON	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST SYLVESTER MURPHY			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET CILLEN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 578-03-7425	17 INFORMANT (DAUGHTER) ADDRESS ROBERTA SHEPPARD, 2006 LONGMEAD RD. 20906		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CEREBROVASCULAR DUE TO, OR AS A CONSEQUENCE OF ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC VASCULAR DISEASE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 HRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) <u>the hospital</u> attended the deceased from <u>20 FEB 1985</u> to <u>20 FEB 1985</u> , that (I) <u>last</u> saw the deceased alive on <u>20 FEB 1985</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>do</u> (did) <u>not</u> view the body after death.					
22b SIGNATURE <u>Walter E. Goetz MD</u>			22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d DATE SIGNED 20 FEB 85	
22e PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH MD			22f ADDRESS 2309 SHOREFIELD ROAD WHEATON MD		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 2/22/85	23c NAME OF CEMETERY OR CREMATORY MOUNT OLIVET CEMETERY	23d LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.		
24 FUNERAL DIRECTOR RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009			25a DATE REC'D. BY REGISTRAR FEB 25 1985	25b REGISTRAR'S SIGNATURE <u>Richard Rapp</u>	

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

05737

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>George Alvin MURRAY</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>02 25 85</i>		2b. HOUR <i>6 P.M.</i>	
3. SEX <i>Male</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>05 19 11</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.	
10. CITY OR TOWN OF DEATH <i>Wheaton</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University Convalescent Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>None</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>			13b. COUNTY	13c. CITY OR TOWN	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ralph Murray</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edna Mason Murray</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>216-82-7902</i>		17. INFORMANT <i>5723 Harford Rd. Ralph Murray, Baltimore, Md. 21214</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

*acute cardio respiratory arrest*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Sudden

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

arteriosclerotic heart disease

DUE TO, OR AS A CONSEQUENCE OF

10 years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <i>2/25</i> 19 <i>85</i> to <i>2/25</i> 19 <i>85</i> , that (2) I last view the deceased alive on <i>2/25</i> 19 <i>85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE <i>Myron L. Lenkin</i>		DEGREE		22c. DATE SIGNED <i>2/25/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MYRON L. LENKIN</i>		22e. ADDRESS <i>2309 Shorefield Road Wheaton Md</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>2/28/85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Asbury Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Princess Anne Somerset Md.</i>
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24. FUNERAL DIRECTOR
NAME ADDRESS
James L. Hinman Princess Anne

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 04 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report
describes the general situation
of the country and the
state of the economy.

2. The second part of the report
describes the results of the
survey and the findings of the
research.

3. The third part of the report
describes the conclusions of the
research and the recommendations
for further action.

4. The fourth part of the report
describes the methods used in the
survey and the results of the
analysis.

5. The fifth part of the report
describes the results of the
survey and the findings of the
research.

6. The sixth part of the report
describes the conclusions of the
research and the recommendations
for further action.

7. The seventh part of the report
describes the methods used in the
survey and the results of the
analysis.

8. The eighth part of the report
describes the results of the
survey and the findings of the
research.

9. The ninth part of the report
describes the conclusions of the
research and the recommendations
for further action.

10. The tenth part of the report
describes the methods used in the
survey and the results of the
analysis.

11. The eleventh part of the report
describes the results of the
survey and the findings of the
research.

12. The twelfth part of the report
describes the conclusions of the
research and the recommendations
for further action.

13. The thirteenth part of the report
describes the methods used in the
survey and the results of the
analysis.

14. The fourteenth part of the report
describes the results of the
survey and the findings of the
research.

15. The fifteenth part of the report
describes the conclusions of the
research and the recommendations
for further action.

16. The sixteenth part of the report
describes the methods used in the
survey and the results of the
analysis.

17. The seventeenth part of the report
describes the results of the
survey and the findings of the
research.

18. The eighteenth part of the report
describes the conclusions of the
research and the recommendations
for further action.

19. The nineteenth part of the report
describes the methods used in the
survey and the results of the
analysis.

20. The twentieth part of the report
describes the results of the
survey and the findings of the
research.

21. The twenty-first part of the report
describes the conclusions of the
research and the recommendations
for further action.

22. The twenty-second part of the report
describes the methods used in the
survey and the results of the
analysis.

23. The twenty-third part of the report
describes the results of the
survey and the findings of the
research.

24. The twenty-fourth part of the report
describes the conclusions of the
research and the recommendations
for further action.

25. The twenty-fifth part of the report
describes the methods used in the
survey and the results of the
analysis.

26. The twenty-sixth part of the report
describes the results of the
survey and the findings of the
research.

27. The twenty-seventh part of the report
describes the conclusions of the
research and the recommendations
for further action.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

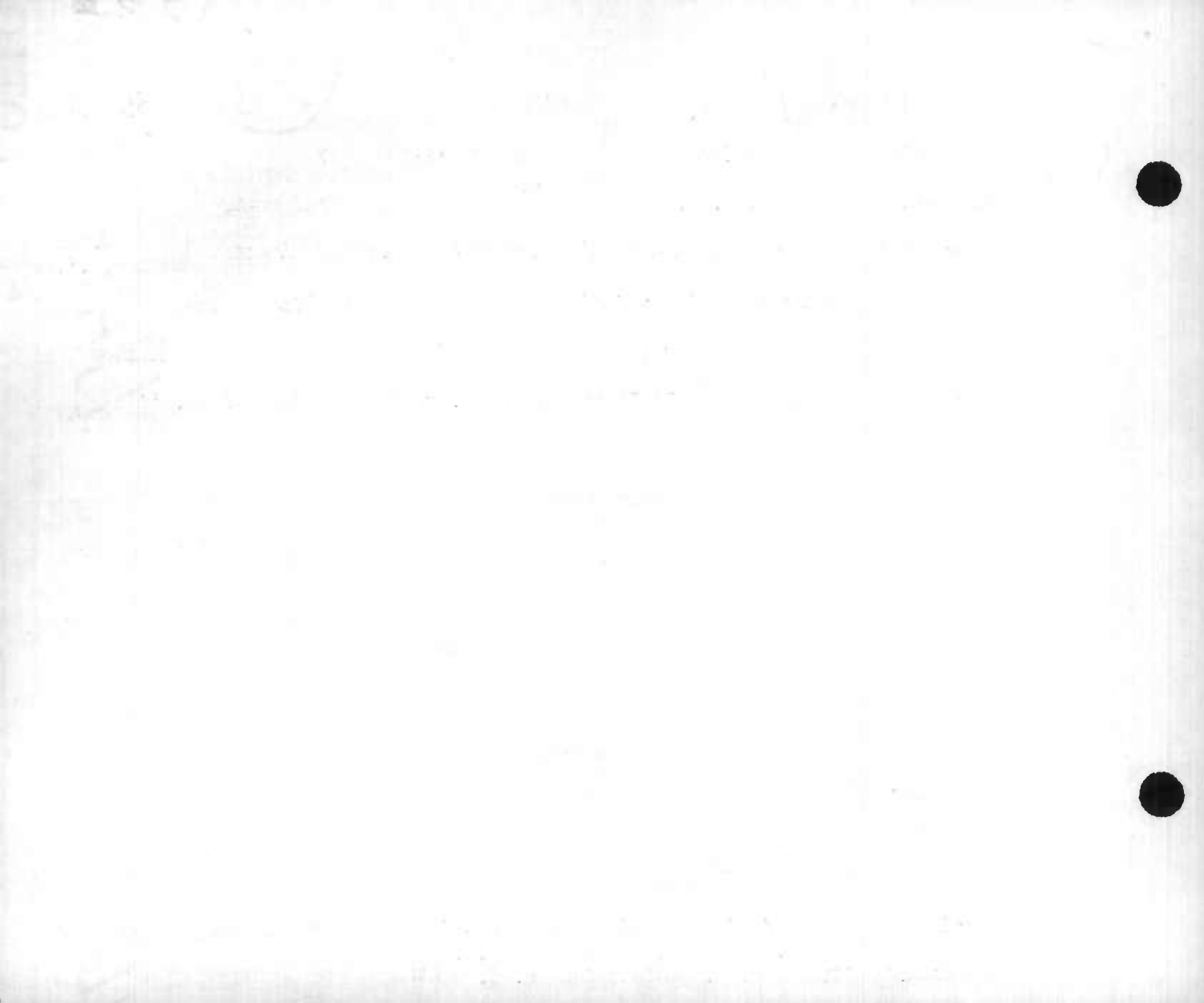
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 05738	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR		
1. DECEASED NAME FIRST MIDDLE LAST MURRAY L. Nash			2. 2 22 85 2:58 PM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 28, 1917	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Deputy Director	12b. KIND OF BUSINESS OR INDUSTRY Dept. of Energy, U.S. Govt.		
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10800 Blossom Lane 20901
14. FATHER'S NAME FIRST MIDDLE LAST Julius Nash		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Lachow			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 103-10-5627		17. INFORMANT ADDRESS Laura R. Nash Same as No. 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-18</u> , 19 <u>85</u> , to <u>2-22</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2-21</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Phillip W. Poth, MD</u>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Phillip W. Poth, MD		22e. ADDRESS 831 University Blvd. East, Suite 32, Silver Spring Md 20903			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/25/1985		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden Falls Church, Virginia	
24. FUNERAL DIRECTOR NAME Donald M. Stein		24b. ADDRESS 232 Carroll Street, N. W. Washington, D. C.		25a. DATE REC'D. BY REGISTRAR FEB 27 1985	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BP _____



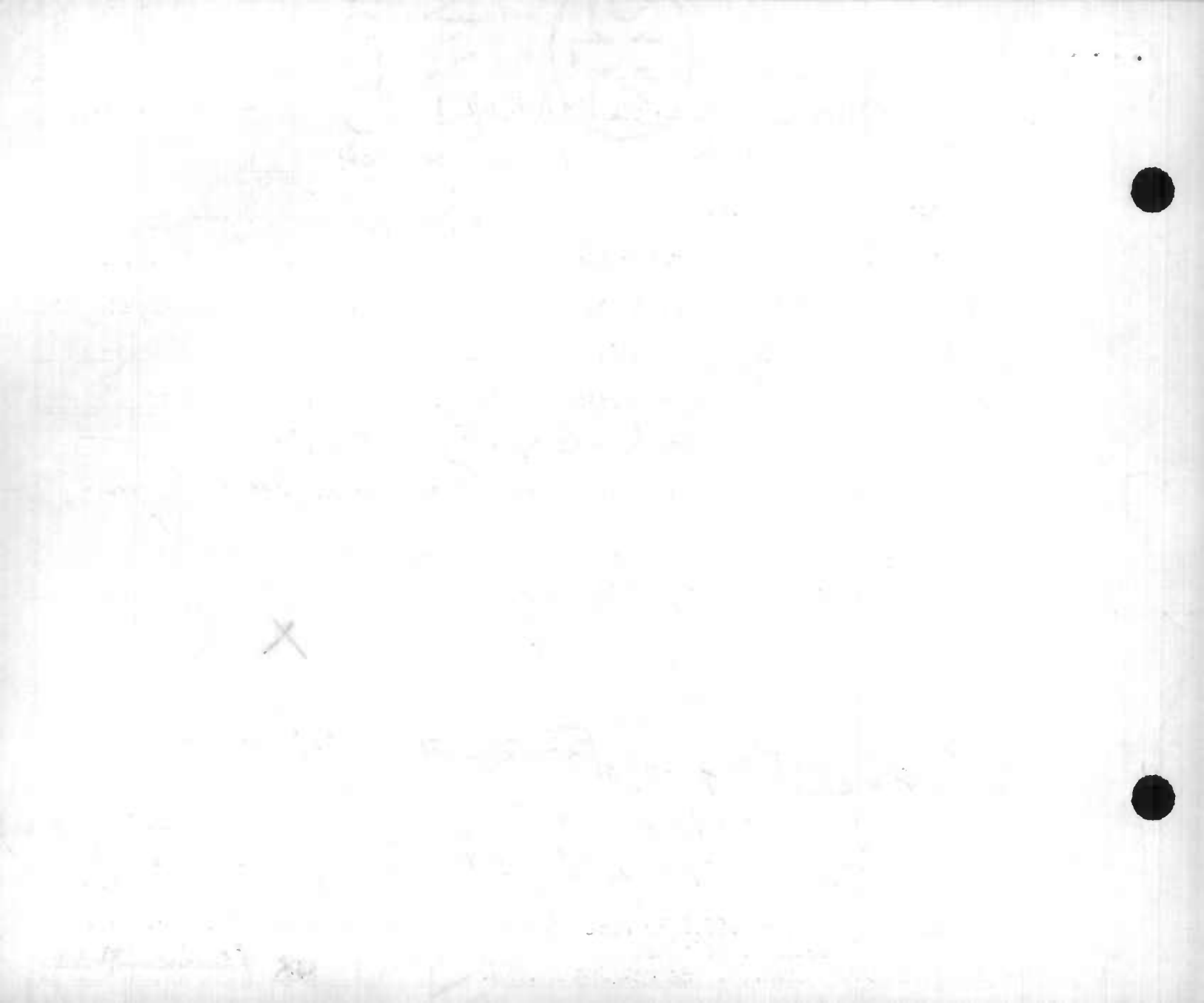
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 7 3 9

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Pinnacle Camplin NAYLOR			2a. DATE OF DEATH MONTH DAY YEAR 2-24-85			2b. HOUR 6:10 P M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7 21 60		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor		12b. KIND OF BUSINESS OR INDUSTRY G.A.O.	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Alkie Odis Camplin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Peake			13e. STREET ADDRESS / ZIP CODE 17531 Shenandoah Court 20904			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-58-0965		17. INFORMANT ADDRESS Daniel A. Naylor's Son Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac-Ischemic, Supt (b) Arterio-Sclerotic Embolism, Choro (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Pneumonia, Sep-Ticemia.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
21g. Certify that (I) (this hospital) attended the deceased from Feb 12 85 to Feb 24 85, that (I) (we) lost saw the deceased alive on Feb 24 1985 and that in my (our) opinion death occurred on the date and hour and from the causes stated									
22a. SIGNATURE Benjamin H. Runkel, MD			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-25-85			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin H. Runkel, MD			22e. ADDRESS 3700 Forest St. Ar. Md. 20008						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 27, 1985		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.		
24. FUNERAL DIRECTOR NAME Francis J. Collins			ADDRESS 500 University Blvd., W. Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR MAR 1 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MARTIN ERNEST NEDELL				2a. DATE OF DEATH MONTH DAY YEAR FEB 2, 85		2b. HOUR MIN. 3 45 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 24, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SYLVAN MANOR NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY FURNITURE	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MEYER N. NEDELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH MAY GOLDBERG		16. STREET ADDRESS / ZIP CODE 10100 NEW HAMPSHIRE AVE. 20903			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 030-07-0449		17. INFORMANT ADDRESS MARTIN E. NEDELL (SELF) SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF BLADDER DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from JAN 18, 1985 to FEB 2, 1985 , that (we) last saw the deceased alive on FEB 1, 1985 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)							
22b. SIGNATURE Walter E. Goodrich MD				22c. DATE SIGNED 2 FEB 85		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOODRICH MD				22f. ADDRESS 2309 SHOREFIELD RD SILVER SPRING MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE FEB/2/85		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDAKE PG CO. MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS CHAMBERS FUNERAL HOME SILVER SPRING, MD.				25a. DATE REC'D. BY REGISTRAR FEB 06 1985			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP _____

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Russell H. Neugent			2a. DATE OF DEATH MONTH DAY YEAR February 11, 1985			2b. HOUR 8:20 A.M.				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3-28-02		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY WSSC		
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Brinklow		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20001 New Hampshire Ave. 20862		
14. FATHER'S NAME FIRST MIDDLE LAST William T. Neugent				15. MOTHER'S MAIDEN NAME MIDDLE LAST Ellen E. Holland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-26-4796		17. INFORMANT ADDRESS Maude N. Hill (Sister) same as Above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								710 yr.		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Emphysema</u>								710 yr.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Prostatic carcinoma</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 5</u> , 19 <u>85</u> , to <u>Feb. 11</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Feb. 10</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Frank J. Mayo</u>					DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>2-11-85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FRANK J. MAYO</u>					22e. ADDRESS <u>16220 Frederick Rd. Githersburg, Md. 20877</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-14-85		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg. Md.		
24. FUNERAL DIRECTOR NAME George R. Snowden					246 N. Washington St. Rockville, Md. 20850		25a. DATE REC'D BY REGISTRAR <u>FEB 14 1985</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Albert E Neviaser</i>			02 06 85			8 35 A M			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>04 05 12</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>72</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County, MD.</i>			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Mail Carrier (Ret.)</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Post Office</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Isaac M. Neviaser</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Eva Edlavitch</i>		13e. STREET ADDRESS <i>10310 Duvawn Place (20902)</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWII</i>		17. INFORMANT <i>Silver Spring, Md. 20903</i> <i>David Neviaser; 8500 New Hampshire Ave., #326;</i>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Acute myocardial infarction*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*1 hour*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Coronary artery disease*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Histiocytic malignant lymphoma

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>July 26, 1983</i> to <i>FEB 6, 1985</i> , that (I) (we) lost saw the deceased alive on <i>FEB 6, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Hubert J. Alpert, MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>2/6/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HUBERT J. ALPERT, MD</i>				22e. ADDRESS <i>8630 FENTON ST SILVER SPRING, MD 20910</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/8/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>D.C. Lodge Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i>				25. DATE REC'D. BY REGISTRAR <i>FEB 11 1985</i>			
1170 Rockville Pike; Rockville, Md. 20852				25b. REGISTRAR'S SIGNATURE <i>John Davidson-Hendricks</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

THE UNIVERSITY OF CHICAGO
LIBRARY

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Esther W. Newell			2a. DATE OF DEATH MONTH DAY YEAR Feb. 28, 1985			2b. HOUR 2:35 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 29, 1899		6. AGE (IN YEARS LAST BIRTHDAY) YRS 85		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Althea Woodland Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1000 Daleview Dr. 20901	
14. FATHER'S NAME FIRST MIDDLE LAST Fred Williams				15. MOTHER'S-MAIDEN NAME FIRST MIDDLE LAST Bertha Tefft					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 579-58-1665		17. INFORMANT ADDRESS Sterling R. Newell 130 Whitmoor Terr. SS, MD 20901			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic coronary artery disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>20 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Parkinson's Disease</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>79</u> , to <u>Feb</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Feb. 27</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>D.V. Young, M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 2-28-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.V. Young, M.D.						22e. ADDRESS 4530 Ct. Ave NW Wash., DC 20008			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar 4, 1985		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, MD		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 WI Ave. NW Wash., DC 20016 ADDRESS									
25. DATE RECEIVED BY REGISTRAR MAR 08 1985 SIGNATURE <u>John Anderson-Rodriguez</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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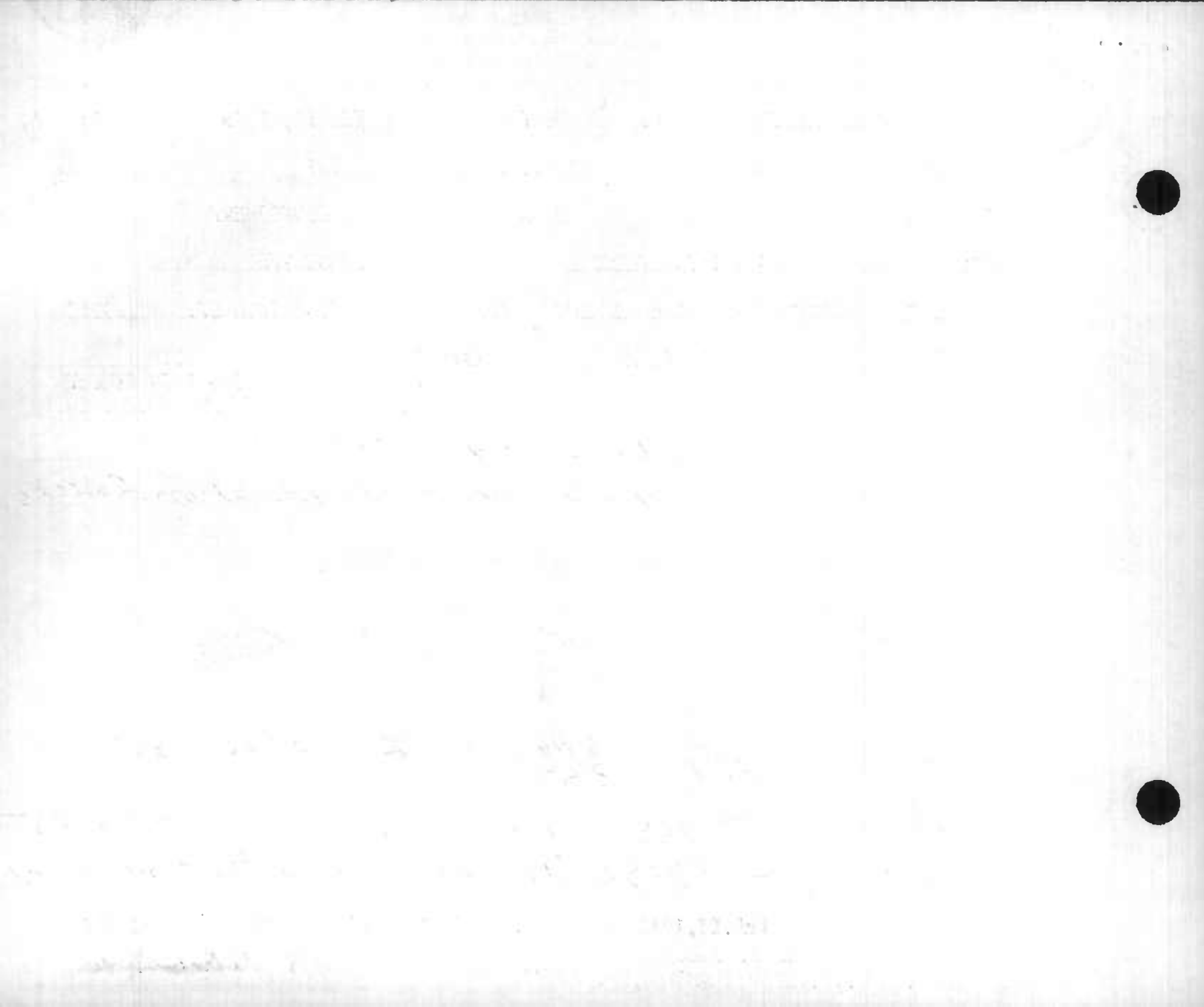
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10/1/1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRIETTA C. NEWTON						2a. DATE OF DEATH MONTH DAY YEAR FEB 18, 1985			2b. HOUR 7:00 A		
3. SEX FEMALE		4. RACE NEGROID		5. DATE OF BIRTH MONTH DAY YEAR DEC 1, 1883		6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TRINIDAD		7b. CITIZEN OF WHAT COUNTRY? TRINIDAD		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8504 16TH STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8508 16TH ST. 20910			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH ALEXANDRA				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURENCINE PHILIP							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS DAUGHTER 8504 16TH STREET VIRGINIA M. KERR SILVER SPRING, MD. 20910					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESP ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Dehydration 2 weeks DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/10 , 19 82 , to 2/10 , 19 85 , that (I) (we) lost saw the deceased alive on 2/6 , 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Penny L. Biskup				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/10/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PENNY L. BISKUP				22e. ADDRESS 10313 Georgia Ave Silver Spring MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Feb. 23, 1985		23c. NAME OF CEMETERY OR CREMATORY MISSION CATHOLIC CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE TOCO TRINIDAD					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25. DATE RECEIVED BY REGISTRAR FEB 25 1985		26. REGISTRAR'S SIGNATURE John Davidson-Randall					
27. ADDRESS 400 UNIV. BLVD., W., SILVER SPRING, MD. 20901											



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
DONG VAN NGUYEN		2/18/85		8:36p M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
MALE	ORIENTAL	MONTH DAY YEAR	87	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
VIET NAM	VIETNAM		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK	WASHINGTON ADVENTIST HOSPITAL	SALESMAN			
13a. STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS / ZIP CODE		
MD	MONTGOMERY	YES <input type="checkbox"/> NO <input type="checkbox"/>	8522 GARLAND AVE. #102 20912		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	16b. SOCIAL SECURITY NO.			
PHONG	NGUYEN	212-98-4841			
17. INFORMANT		ADDRESS			
DAUGHTER		CHAU-LOAN THI NGUYEN SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>NATURAL</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
DANC C. BUI M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DANC C. BUI M.D.		400 UNIVERSITY BLVD. EAST SILVER SPRING, M.D. 20901			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		FEB. 23, 1985		GATE OF HEAVEN	
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME		FEB 25 1985		Francis J. Collins	
500 UNIVERSITY BLVD., W. SILVER SPRING, MD.					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 05740

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Eugenia R. — Nickolaus		2a. DATE OF DEATH MONTH DAY YEAR Feb. - 4 - 85	
2. SEX Female		2b. HOUR 1:45 M	
3. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 30 02	
4. AGE (IN YEARS LAST BIRTHDAY) 82		6. IF UNDER 1 YEAR MONTHS DAYS 8/30/02 X 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Wheaton, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Convalescent Hh.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bakery, Baker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	
13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 8409 GROVE STREET 20910			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEF PIERRE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DECKER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 152-32-5542	
17. INFORMANT ADDRESS EDWARD W. NICKOLAUS SAME AS 13 HUSBAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intracerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO: WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE WALTER E. GOOZH, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED		22d. ADDRESS 2309 SHOREFIELD RD. WHEATON, MD.	
23a. BURIAL, CREMATION, REMOVAL (SEE CITY)		23b. DATE FEB. 7, 1985	
23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE N. ARLINGTON HUDSON N.J.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR FEB 7 1985	
500 UNIVERSITY BLVD., W. SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Francis J. Collins	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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85 05747

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) FRANK WOOD NOBLE			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 1 1985		2b. HOUR 12:20 P
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 9 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY PUBLIC HEALTH	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BETHESDA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE VERNON NOBLE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEATRICE WOOD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW 11 267-20-3694		17. INFORMANT ADDRESS JEAN G. NOBLE, 10004 BELHAVEN ROAD, BETHESDA, MD 20817	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA DUE TO, OR AS A CONSEQUENCE OF (b) LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NO					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 28 19 85 , to FEBRUARY 1 19 85 , that (I) (we) lost saw the deceased alive on FEBRUARY 1 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John B. Hermiller</i>		DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 3 Feb 85	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) J. B. HERMILLER, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 2/4/85	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852			25a. DATE REC'D. BY REGISTRAR FEB 7 1985	25b. REGISTRAR'S SIGNATURE <i>John B. Hermiller</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be filed with the funeral director within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be filed with the funeral director within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified (in case).



CHICKEN
LEAKERS
CHICKEN

1980

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 7 4 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE M. NORRIS			2a. DATE OF DEATH MONTH DAY YEAR FEB 9 1985		2b. HOUR MIN. PM 6:45 PM
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JAN 2, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.	
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY JOHNS HOPKINS LAB
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 14204 GREENSPAN LANE 20853		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN J. HARTMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE M. MILLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-18-7299		17. INFORMANT ADDRESS EPPA L. NORRIS, JR. SAME AS 13 HUSBAND	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

20 min

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) Emphysema

DUE TO, OR AS A CONSEQUENCE OF

(c)

10 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/5 19 85 to 2/9 19 85, that (I) (we) last saw the deceased alive on 1/5 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did not) view the body after death.			
22b. SIGNATURE Carl I. Schoenberger	DEGREE MD.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/10/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl I. Schoenberger		22e. ADDRESS 16220 Frederick Rd Gaithersburg	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 2/13/85	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR FEB 19 1985	
		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked on item 18, show any injury or other traumatic event, the medical examiner must be notified at once.

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Office
of the
Secretary
of the
Treasury

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 1- FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Alia			FIRST MIDDLE LAST Opal			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2/27 19 85			7b. HOUR 10:00 A. M.						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 15, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 2/27 19 85		7d. HOUR 10:00 A. M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11700 Old Columbia Pike, #1605				12a. USUAL OCCUPATION (TYPE OF WORK) SECRETARY				12b. KIND OF BUSINESS OR INDUSTRY LEGAL			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS zip-----20904 11700 Old Columbia Pike, #1605					
14. FATHER'S NAME JACOB MIDDLE						15. MOTHER'S MAIDEN NAME LEDICIA MIDDLE VIVAS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)						16b. SOCIAL SECURITY NO. 088-36-9056 D		17. INFORMANT JACQUES E. OPAL, 11700 OLD COLUMBIA PIKE, SILVER SPRING, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) arteriosclerotic cardiovascular disease. DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Fracture of left hip.															
19a. DATE OF OPERATION 1/12/85				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture of left hip.								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12/12 19 84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell at home.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Old Columbia Pike, Silver Spring, Montgomery, Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>[Signature]</i>				TITLE (SPECIFY) Deputy				DATE SIGNED 2/27/85							
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.											
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 2/28/1985		23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION CEMETERY				23d. LOCATION QUEENS, COUNTY NEW YORK					
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.												25a. DATE REC'D. BY REGISTRAR MAR 04 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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Montgomery Silver Spring 1750 Old Columbia Pike, 4065

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Old Columbia Pike, Silver Spring, Montgomery,

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Deputy Secretary

silver Spring, Montgomery, Md.

John S. Rogers, M.D.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FIRST MIDDLE LAST Charlotte E. Organ		February 2, 1985		3:24 A.M.	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR 5 6 1988	86 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
New York	USA		Montgomery County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	CARRIAGE HILL-BETHESDA		Ret. U.S. Gov't		Bureau Public Roads
13a. STATE	13b. CITY OR TOWN	13c. STREET ADDRESS / ZIP CODE	13d. INSIDE CITY LIMITS?		
D.C.	Washington	3133 Conn. Ave., N.W. 20008	YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		ADDRESS		
Michael Organ	Ida Morrissey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17 INFORMANT			
yes	577-56-0790	Mary M. Connelly. 806-15th St., N.W. wash.D.C.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A. Carcinoma of Colon</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>84</u> , to <u>February 2</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>February 2</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. DEGREE <u>Thomas L. Hartman M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/2/1985</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas L. Hartman M.D.		22e. ADDRESS 3301 New Mexico Ave N.W. Wash.D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Cremation	2/5/85	Cedar Hill Crematory	Suitland Maryland		
24 FUNERAL DIRECTOR Joseph Gawler & Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 11 1985			

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February 2, 1958

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February 2, 1958

2/2/58

3301 New Mexico Ave. N.W. Wash. D.C.

Thomas L. Hartman N.W.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Renit C. Orlando								2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Feb 17, 1985		2b. HOUR 3:03p	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 09, 1914		6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD Feb 17, 1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PARTS MANAGER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. CITY Montgomery		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 4013 Adams Drive		20902	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK ORLANDO				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EUGENIA LANDESio							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT OLGA H. ORLANDO		ADDRESS SAME AS 13		WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Richard P. Whelton				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER DATE SIGNED Feb 17, 1985			
EXAMINER'S NAME (TYPE OR PRINT) RICHARD P. WHELTON				ADDRESS 2203 Bldg. at Ave College Park MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 2/19/85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR FEB 26 1985				25b. REGISTRAR'S SIGNATURE John Davidson			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

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1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Doris W. Osborne		Feb. 24, 1985		2:46 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
Female	Caucasian	MONTH DAY YEAR 11 08 13	71 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Massachusetts	U.S.A.		Montgomery County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Rockville	Shady Grove Adventist Hospital	Housewife	Own Home		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Gaithersburg	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		403 Russell Ave #312 20877
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Archibald - Jones		FIRST MIDDLE LAST Alice - Patch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No -		217-36-8406		Owen E. Osborne 403 Russell Ave Md. 20877	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration of Food particle</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alzheimer's Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-19-85</u> 19 <u>85</u> , to <u>2-23-85</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/23/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Tibor Frekko, M.D.</u>		DEGREE <u>MD</u>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Tibor Frekko, M.D.		19211 Montgomery Ave., Gaithersburg, Md.			
23a. BURIAL, CREMATION, REMOVAL <u>Cremation</u>		23b. DATE <u>2/24/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee Crematory</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. LOCATION CITY OR TOWN COUNTY STATE		23f. LOCATION CITY OR TOWN COUNTY STATE	
Washington DC		Washington DC		Washington DC	
24. FUNERAL DIRECTOR NAME <u>GARTNER-SANDISON F.H.</u>		24b. ADDRESS <u>316 E. DIAMOND AVENUE</u>		25a. DATE REG. BY REG. BUREAU <u>FEB 28 1985</u>	
GAITHERSBURG, MD.		GAITHERSBURG, MD.		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) George H. OWENS					2a. DATE OF DEATH MONTH DAY YEAR 2-9-85			2b. HOUR 6¹⁸ PM		
3. SEX TYPE A MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Construction		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST George H. Owens					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Barnes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-12-1389		17. INFORMANT ADDRESS Ellen Owens (wife) same as Above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST, CARDIOVASCULAR SHTOCK									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Months	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIAC DISEASE									10 YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c) IMPROVED CORONARY VASCULAR DISEASE									10 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: TERMINAL CARCINOMA LUNG - METASTATIC TO LIVER & BONE. DIABETES										
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan 2, 1980 to Jan 2, 1985 , that (I) (we) lost saw the deceased alive on Jan 2, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE DR. GABRIEL KOS			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/10/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GABRIEL KOS			22e. ADDRESS 13 E DEER PARK DR. GAITHERSBURG, MD 20878							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-15-85		23c. NAME OF CEMETERY OR CREMATORY Emory Grove Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Montg. Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS 246 N. Washington St. Rockville, Md. 20850		25a. DATE REC'D. BY REGISTRAR FEB 13 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 / 5 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MICHAEL D PAPPAS			2a. DATE OF DEATH MONTH DAY YEAR 2.14.85			2b. HOUR 7:01AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 12 14		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALBANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurateur		12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9412 Warren Street 20910	
14. FATHER'S NAME FIRST MIDDLE LAST Demetrios Pappas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sofia Kalantzis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT ADDRESS Angeliki Pappas-wife-(same as 13e)			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

bronchopneumoniaAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**2 days**

DUE TO, OR AS A CONSEQUENCE OF

(b)

seizure disorder**10 days**

DUE TO, OR AS A CONSEQUENCE OF

(c)

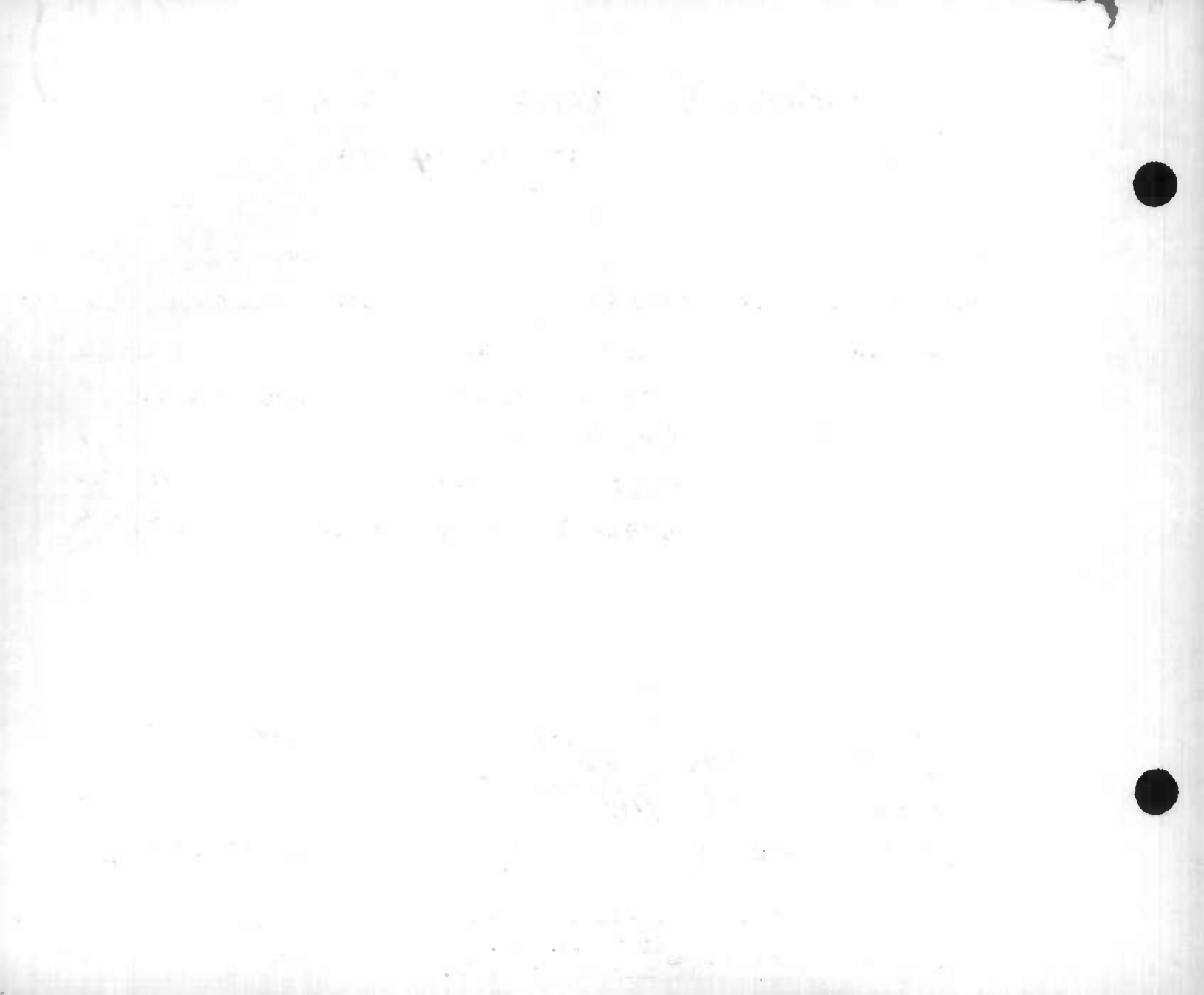
brain tumor and colon cancer**3 years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/14 19 85 , to 2/14 19 85 , that (I) (we) lost saw the deceased alive on 2/13 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bruce A. Silver, MD				DEGREE		22c. DATE SIGNED 2/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE A. SILVER, MD				22e. ADDRESS 106 Irving St. N.W., Wash. DC 20010 #421			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR FEB 19 1985	
				25b. REGISTRAR'S SIGNATURE Handall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be buried with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner is required to complete the following section.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
ROBERT HAROLD PATRICK					FEBRUARY, 2, 1985					7:20 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		CAUCASIAN		JULY, 15, 1941		43 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA		U.S.A.				MONTGOMERY COUNTY, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		NAVAL HOSPITAL				CARPENTER		CONSTRUCTION			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
13a. STATE 13b. COUNTY VIRGINIA LOUDON					13c. CITY OR TOWN STERLING PARK		13e. STREET ADDRESS / ZIP CODE 103 W. CHARLOTTE ST. / 22170				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
ROBERT HENRY PATRICK					VIRGINIA GRAY FULCHER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
YES					9/59 to 6/63 228-52-5153		NANCY JEAN PATRICK SAME AS ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SMALL CELL CARCINOMA OF THE LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY, 14, 1985</u> , to <u>FEBRUARY, 2, 1985</u> , that (I) (we) lost saw the deceased alive on <u>FEBRUARY, 2, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>E. S. Killeavy</u>						DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>03 Feb 85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. S. KILLEAVY, MC, USN						22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITOL REGION, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
BURIAL			2/5/85		STERLING CEMETERY		STERLING (LOUDON) VIRGINIA				
24. FUNERAL DIRECTOR J. BERKLEY GREEN, 721 ELDEN ST., HERNDON						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						FEB 11 1985		<u>John Killeavy</u>			

1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

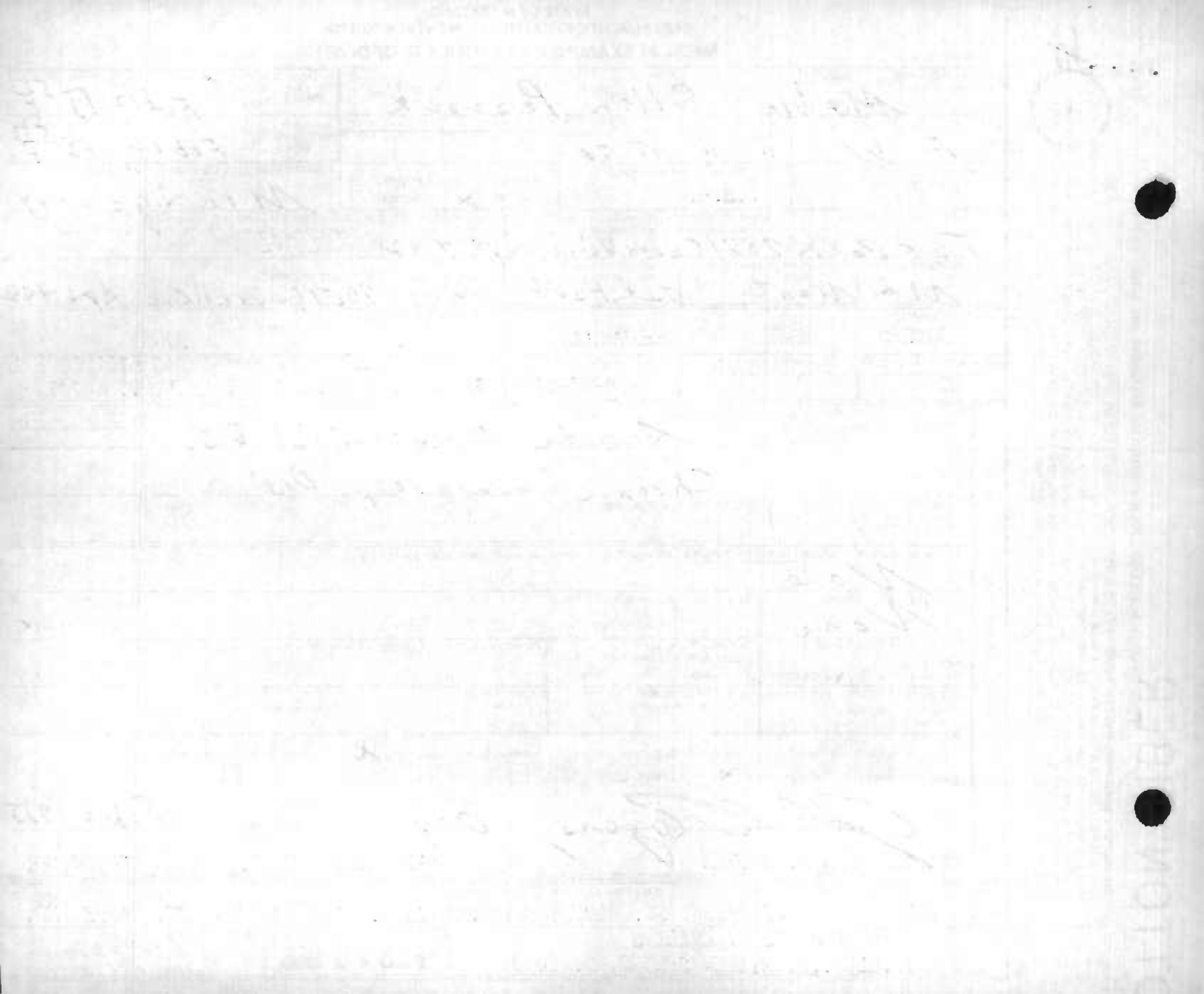
DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MABEL		MIDDLE Ellen		LAST Pezcock		2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Feb 12, 1985		2b. MONTH Feb DAY 12 YEAR 1985		2c. DATE PRONOUNCED DEAD Feb 12 1985		2d. HOUR 5:30 MIN PM			
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH 11 DAY 11 YEAR 98	6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Monterey, MD.			
10. CITY OR TOWN OF DEATH Tak Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7051 Carroll Ave Apt 402				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY 20912		13a. STATE MD			13b. CITY OR TOWN Monterey		
14. FATHER'S NAME FIRST JOSEPH MIDDLE HENRY LAST GREENWELL		15. MOTHER'S MAIDEN NAME FIRST ADA MIDDLE JONES LAST JONES		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-38-7106		17. INFORMANT SON		ADDRESS 15803 MILLBROOK LAUREL, MD. 20707					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis; DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Cardioresp. Dis; DUE TO, OR AS A CONSEQUENCE OF (c) 												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
None															
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET 		CITY OR TOWN 		COUNTY 		STATE 					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D. Dep.		MEDICAL EXAMINER				DATE SIGNED Feb 12, 1985		EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS					
ADDRESS 1919 SEMINARY RD., SILVER SPRING, MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/15/85		23c. NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CHURCH CEME.				23d. LOCATION CITY OR TOWN LEONARDTOWN		COUNTY ST. MARYS		STATE MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR FEB 19 1985				25b. REGISTRAR'S SIGNATURE John Davidson-Randall							
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hazel L. Pease				2b. MONTH DAY YEAR FEB 1 85			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Sept. 30, 1905		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 259 Congressional Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. COUNTY Montgomery				13b. CITY OR TOWN Rockville			
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS 259 Congressional Lane			
14 FATHER'S NAME FIRST MIDDLE LAST August Frederick Namanny				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Johanna Bertelsin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 047-10-54231		17 INFORMANT ADDRESS Louise F. Pease, same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 mos</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 63 to 2/1 19 85, that (I) (most) saw the deceased alive on 12/15 19 84, and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. G. Hall, M.D.				22c. ADDRESS 615 West Montgomery Avenue Rockville, Maryland 20850		22d. DATE SIGNED 2/1/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 5, 1985		23c. NAME OF CEMETERY OR CREMATORY Northwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wilson, Connecticut	
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850				25a. DATE REC'D. BY REGISTRAR FEB 5 1985		25b. REGISTRAR'S SIGNATURE L. Davidson-Randall	

Feb 1 22

Waterbury, Conn
Brent

W. M. H. H.
15/10 21
2/11/22

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 7 5 8

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Beulah K Pence			2a. DATE OF DEATH MONTH DAY YEAR 02 20 85			2b. HOUR 11:55 PM			
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 4 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William L. Klinehanse			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Lacy			13e. STREET ADDRESS / ZIP CODE 18430 Brooke Grove Rd. 20832			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-32-0702		17. INFORMANT ADDRESS Ethel Darby. 11495 Columbia Pike, Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Cardiac Respiratory</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARREST</u> Senile - Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) <u>Feeding gastrostomy</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One hr.	
								Years	
								3 hrs.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> 19 <u>80</u> to <u>2/21</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/20</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Gustavo S. Belaval</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>2/21/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Gustavo S. Belaval</u>				22e. ADDRESS <u>Leisure World Medical Center</u> <u>Silver Spring, Maryland 20906</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/25/1985		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cen.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc.</u> <u>5190 Wisc. Ave., N. W. Wash., D.C.</u>				25a. DATE REC'D. BY REGISTRAR <u>FEB 26 1985</u>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED
JAN 11 1967
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows]

1/10/67
[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or initialed, there was any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Benjamin Perchick</i>						2a. DATE OF DEATH MONTH <i>2</i> DAY <i>11</i> YEAR <i>85</i> 2b. HOUR <i>5:36 p.m.</i>					
3. SEX <i>male</i>		4. RACE <i>caucasian</i>		5. DATE OF BIRTH MONTH <i>4</i> DAY <i>15</i> YEAR <i>1900</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Poland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Owner (Ret.)</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Liquor Store</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i> COUNTY <i>Montgomery</i>		13b. CITY OR TOWN <i>Silver Spring</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>8201 16th Street, #1011; 20910</i>					
14. FATHER'S NAME FIRST <i>Abraham</i> MIDDLE <i></i> LAST <i>Perchick</i>				15. MOTHER'S MAIDEN NAME FIRST <i>Sylvia</i> MIDDLE <i></i> LAST <i>Wool</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			
16b. SOCIAL SECURITY NO. <i>578-46-4848</i>				17. INFORMANT <i>Dina Perchick</i>				ADDRESS <i>8201 16th St., #1011; S.Spg., Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bilateral Lobar Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Respiratory infection</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Cerebral vascular arteriosclerosis - Diabetes Mellitus</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr 15 min</i> <i>3 days</i> <i>1 week</i>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i></i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>1948</i> to <i>2-11</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>2-11</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.											
22b. SIGNATURE <i>William Kurstin MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>2-11-85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William Kurstin MD</i>				22e. ADDRESS <i>1145 19th St. NW Wash. DC</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/13/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Beth Shalom Cong. Cemetery; Capital Heights, Maryland</i>		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i> ADDRESS <i>1170 Rockville Pike; Rockville, Md. 20852</i>						25a. DATE REC'D. BY REGISTRAR <i>FEB 20 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH										2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MONTH		DAY		YEAR		2b. HOUR	
Kenneth W. Perkins								2-20		85		8		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY	
Male	Cauc.	August 1, 1934		50 YRS.						2 21		85		730	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Washington, D.C.		United States				Montgomery, MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		13210 Twinbrook Parkway						Fireman-D.C. Fire				Department			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13210-Twinbrook Parkway							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				ADDRESS							
FIRST MIDDLE LAST				FIRST MIDDLE LAST				Rockville, MD 20852							
Robert - Perkins				Marjorie - Hackley											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT							
No				577-38-1458				Gregory M. Perkins (Son) 5947-Valerian Lane,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Cardio Respiratory arrest.															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b) Gastrointestinal Hemorrhage															
DUE TO, OR AS A CONSEQUENCE OF															
(c) Cirrhosis of Liver															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED			
John Tauber				M.D. Deputy								2-21-85			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
John Tauber				8218 Wisconsin Ave.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				Feb. 25, 1985				Cedar Hill Cemetery				Suitland, Prince George Co., MD			
24. FUNERAL DIRECTOR															
J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002															
25. REGISTRAR'S SIGNATURE															
John Davidson-Randall															

FEB 28 1985



August 1, 1934

United States

Washington, D. C.

1934-1935

Executive Order

Executive Order (No. 571-V)
George H. Davis

1934-1935



George H. Davis, Secretary of the Interior

1934-1935

1. 1. 1934

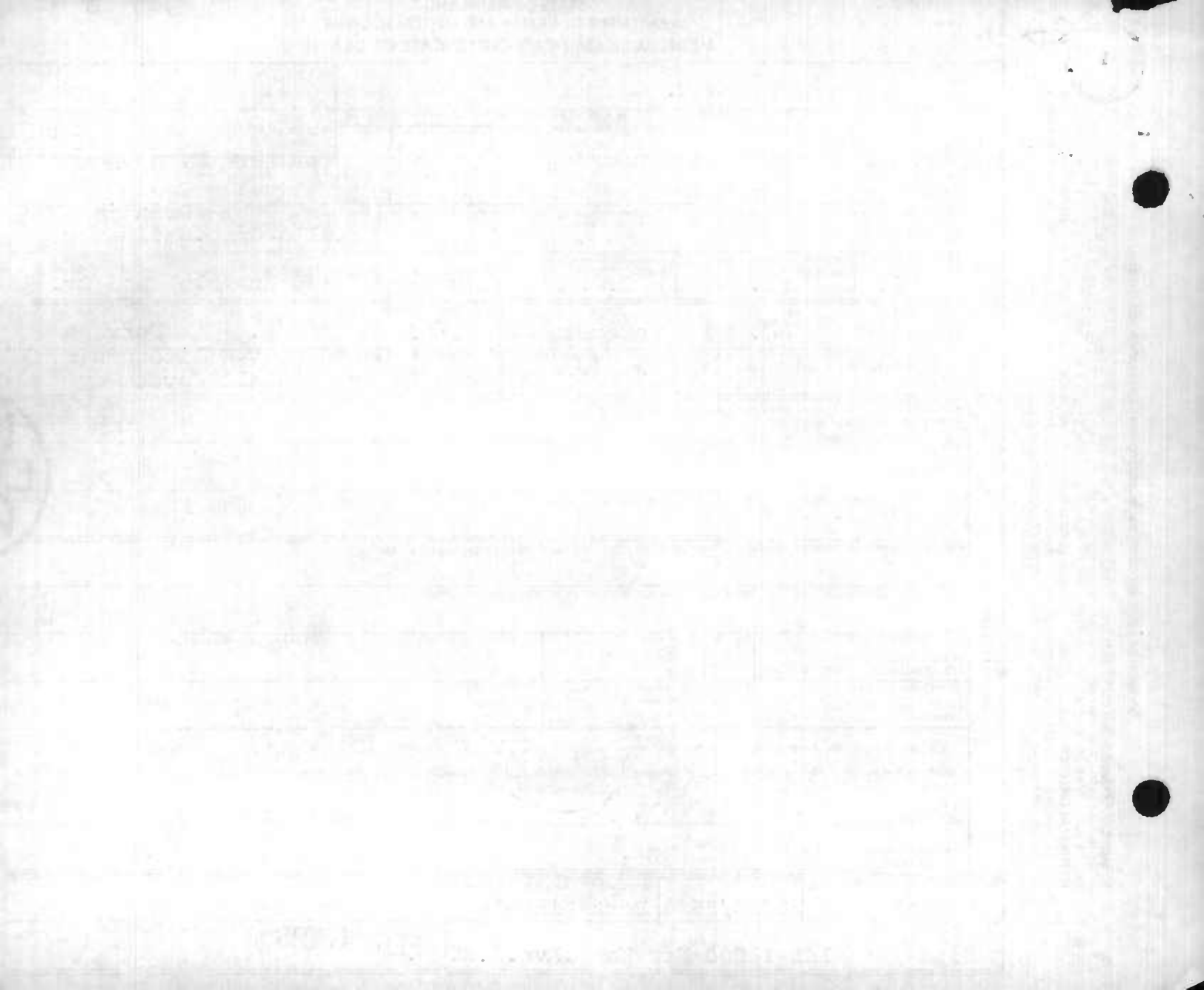
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
ROLAND E. PETERSON								DATE ESTIMATED		2		22		19 85		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	9 12 05		79 YRS.						2		22		19 85		5:30 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Minnesota		USA		WIDOWED		DIVORCED		Montgomery County								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF BUSINESS OR INDUSTRY)													
Olney		Montgomery General Hospital		McCallis Corp. Estimator													
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS											
Md.		Mont.		S.S.		YES		15424 Bramble Wood Dr.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Perz C. Peterson		Jennie L. Pearson															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT													
None		578 01 1549		John Peterson		32412 Joyce Way											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 1 DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a):		Cranio-cerebral Trauma complicated by pneumonia															
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b):		DUE TO, OR AS A CONSEQUENCE OF													
		(c):															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																	
Schwannoma of cerebello-pontine angle																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				Head Only		YES		NO									
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED													
		P.M. 2/8 19 85		Pedestrian struck by auto													
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION													
NOT WHILE AT WORK		street		15424 Bramblewood Dr. Silver Spring, Md													
22a. I certify that I took charge of the remains described above, held an Autopsy		Inspection		Inquiry		and in my opinion											
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Ann M. Dixon, M.D.		Assistant		2-23-85													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
111 Penn St., Balto., Md. 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		2/25/85		Fort Lincoln		Brentwood		PG		Maryland							
24. FUNERAL DIRECTOR		25a. DATE RECORDED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Hines/Rinaldi		FEB 25 1985															
NAME		ADDRESS															
11800 New Hamp. Ave. S.S. Md.																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. HOUR	
Howard James Pinkley										2.14. 19 85										9:58P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		7c. DATE PRONOUNCED DEAD		2d. HOUR		2e. HOUR							
male		white		1 17 21		64 YRS.				2.14. 19 85		9:58P		9:58P							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
ILLINOIS				U.S.A.								Montgomery MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Bethesda				Suburban Hospital				SALESMAN				DEPT. STORE									
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
MARYLAND				MONTGOMERY		CHEVY CHASE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5105 FAIRGLEN LANE											
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME											
JAMES P. PINKLEY										OLIVE E. FELBECK											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT (SON) ADDRESS													
YES				145-12-7390				RONALD J. PINKLEY, 2620 DUBLIN RD. 20854													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) Cardiac arrest																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary arteriosclerosis																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
				P.M. 19																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION													
								STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE				DATE									
John Tauber				M.D. 2-15-80				MEDICAL EXAMINER				2-15-80									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
John Tauber				8218 W. S. CONSON AVE.																	
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION											
BURIAL				2/25/85		ARLINGTON NATIONAL CEM.				ARLINGTON, VIRGINIA											
24. FUNERAL DIRECTOR NAME																					
RICHARD RAPP, INC.																					
25a. DATE REC'D. BY REGISTRAR																					
FEB 25 1985																					
25b. REGISTRAR'S SIGNATURE																					
John Tauber																					



is

0000-0000-0000-0000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Marie Pocock			2a. DATE OF DEATH MONTH DAY YEAR February 19, 1985		2b. HOUR 8:40 ^A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 15 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE, (STATE OR FOREIGN COUNTRY) St Louis, Mo.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3613 S. Liesureworld Blvd.
14. FATHER'S NAME FIRST MIDDLE LAST Edward M Mueller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian O'Keefe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 489-09-9579		17. INFORMANT ADDRESS Silver Spring, Md. Virginia Hanneman 3613 S. LeisureWorld Blvd.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Intra cerebral hemorrhage.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

① Hypertension. ② Arteriosclerosis.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 19 <u>92</u> , to <u>Feb.</u> , 19 <u>95</u> , that (I) (we) last saw the deceased alive on <u>2/19/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>J. Maltz</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>2/18/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JONATHAN MALTZ		22e. ADDRESS 1311 Prince Philip Drive, Olney, Md. 20822.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE Feb. 19, 1985	23c. NAME OF CEMETERY OR CREMATORY Georgetown U. Med. Sch.	23d. LOCATION CITY OR TOWN COUNTY STATE Washington d.c.
24. FUNERAL DIRECTOR NAME Columbia Mortuary Services WASH., D.C. 20011		25a. DATE REC'D. BY REGISTRAR FEB 25 1985	25b. REGISTRAR'S SIGNATURE John Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician. The law requires that the death certificate be executed by the attending physician. The law requires that the death certificate be executed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

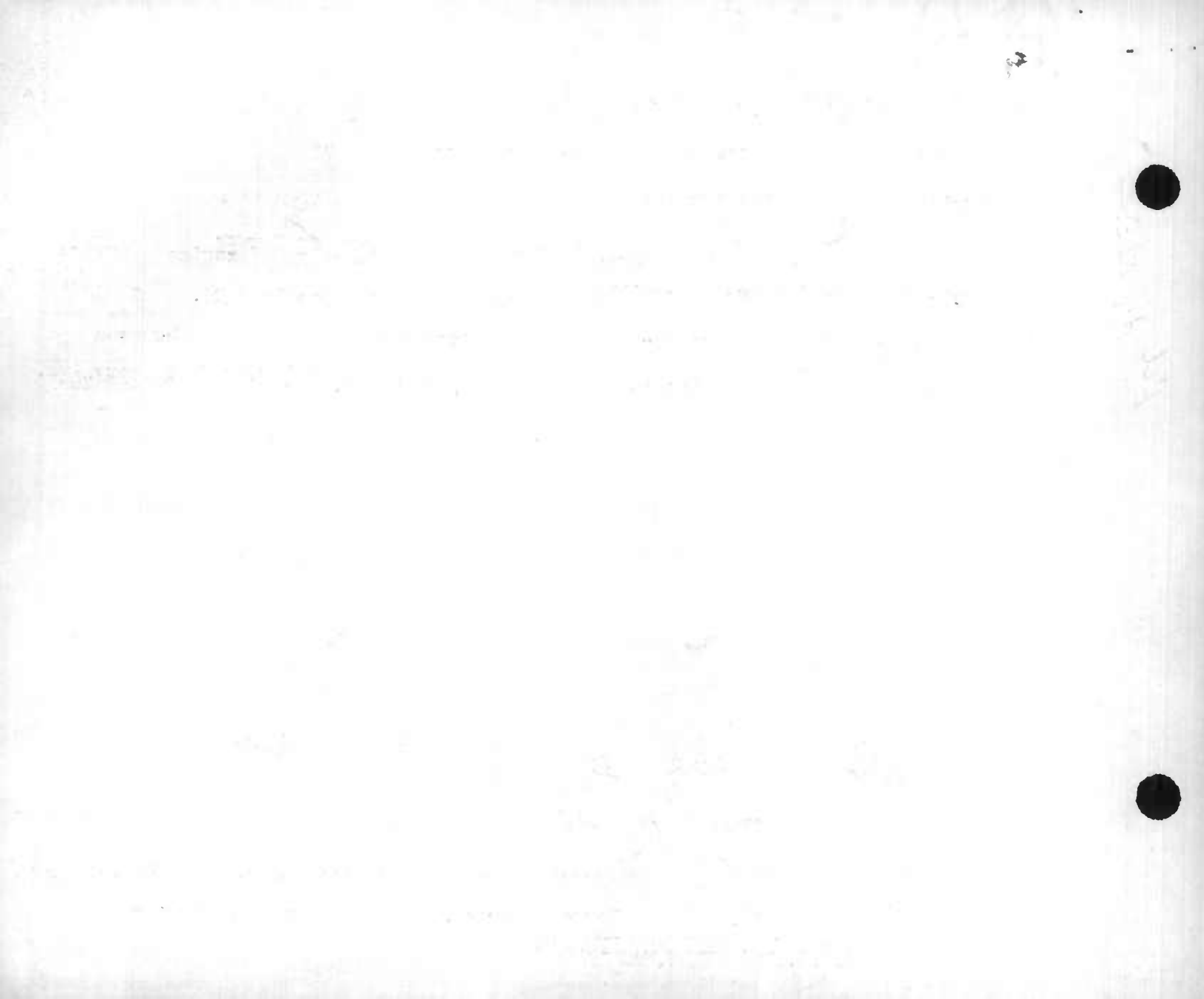
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Ellen POOLE		2a. DATE OF DEATH MONTH DAY YEAR 02 22 85		2b. HOUR 8:55 A	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 21, 1911	
6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. CITIZEN OF WHAT COUNTRY? United States	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital	
12a. USUAL OCCUPATION Manager, Cafeteria		12b. KIND OF BUSINESS OR INDUSTRY Food Service		12c. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Kinder		15. MOTHER'S MAIDEN NAME MIDDLE Margaret Thompson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
17. SOCIAL SECURITY NO. 214 32 9269		18. INFORMANT John F. Poole, Sr.		19. ADDRESS 532 West Montgomery Ave. Rockville, Maryland 20850	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURED THORACIC AORTIC ANEURYSM</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) (this hospital) attended the deceased from <u>2/21</u> 19 <u>85</u> , to <u>2/22</u> 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>2/22</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22a. SIGNATURE Roger Stevenson, Jr. MD		22b. DEGREE MD		22c. DATE SIGNED 2/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER STEVENSON, JR., MD		22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 26, 1985		23c. NAME OF CEMETERY OR CREMATORY Derwood Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Derwood, Maryland		23e. DATE REC'D. BY REGISTRAR FEB 28 1985		23f. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CAROLINE R. POORE						2a. DATE OF DEATH MONTH DAY YEAR 2/9/85				2b. HOUR 1:30 P.M.			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 9 29 1900		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 84		7. NUMBER 1 YEAR YEARS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SCOTLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3015 MAPLE AVENUE				12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) Children (care)		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Takoma Park						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3015 Maple Ave. Tak. Park					
14. FATHER'S NAME FIRST MIDDLE LAST Pat Kneon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pat Kneon				16. ADDRESS 1935 - Upshur St. Tak. Park					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 579-10-6593		17. INFORMANT Annette M. Behan				ADDRESS 1935 - Upshur St. Tak. Park			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Coronary artery Disease (b) arteriosclerotic Heart Dis (c) Stroke PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Stroke						19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME				21c. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2/5/85		21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6116 Robin Hood, Bethesda, Md 20817		22a. SIGNATURE Thos G. Ward DEGREE							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward				22c. ADDRESS 6116 Robin Hood, Bethesda, Md 20817				22d. DATE SIGNED 2/9/85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE Feb 11-1985		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD - P.G. MD.					
24. FUNERAL DIRECTOR NAME TAKOMA FUNERAL HOME - N.W. D.C. 20012				25a. DATE REC'D. BY REGISTRAR FEB 13 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE NOTIFY THE MEDICAL EXAMINER BY TELEPHONE. WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL—TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP_____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND										05788	
DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Lynn BETH Postal										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2/15 19 85	
3. SEX Female										2b. HOUR 12:35 A.	
4. RACE White										2c. DATE PRONOUNCED DEAD 2/15 19 85	
5. DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1955										2d. HOUR 12:35 A.	
6. AGE (IN YEARS) (LAST BIRTHDAY) 30 YRS.											
7a. BIRTHPLACE (STATE OR COUNTY) NEW JERSEY										7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Olney										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY) TEACHER										12b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL	
13a. STATE Maryland										13b. COUNTY Montgomery	
13c. CITY OR TOWN Olney										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 13 Hines Court										zip--20832--	
14. FATHER'S NAME HERMAN B. PACKER										15. MOTHER'S MAIDEN NAME MIDDLE MARCIA SILVERSHEIN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO										16b. SOCIAL SECURITY NO. 146-42-7587	
17. INFORMANT HERMAN B. PACKER,										ADDRESS 13-39 COMERFORD PLACE FAIRLAWN, NEW JERSEY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: IMMEDIATE CAUSE (a) Probable Berry aneurysm. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) None											
19a. DATE OF OPERATION None										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.)	
21f. LOCATION STREET 1919 Seminary Road										CITY OR TOWN Silver Spring	
21g. COUNTY Montgomery										STATE Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE John S. Rogers										TITLE (SPECIFY) Deputy	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.										DATE SIGNED 2/15/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE 2/17/1985	
23c. PLACE OF INTERMENT PASSAIC JUNCTION CEMETERY										23d. LOCATION CITY OR TOWN SADDLE BROOK, NEW JERSEY	
24. DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME										25a. DATE REC'D. BY REGISTRAR FEB 25 1985	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall											

12:35

John S. Rogers, M.D.
Silver Spring, Montgomery, Md.

1919 Seminary Road

Deputy

X

None

None

None

Probable Berry aneurysm.

13 lines Court

Clay

Montgomery

Maryland

Montgomery General Hospital

Clay

Montgomery County

Female white Feb. 14, 1922 30

located

lynn

12:35

12:35

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HILDA Marie POWELL			2a. DATE OF DEATH MONTH DAY YEAR 2 15 85			2b. HOUR 945 P.M.			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 2, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missard, Sweden		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Rockville, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY at home..	
13a. STATE D.C.		13b. COUNTY ---		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5529 39th St. N.W. 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Johan Johanson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alivida Karlsson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Rev. Richard Reichard		ADDRESS 9701 Veirs Dr. Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular accident								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 28 days	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Carcinoma of right tonsillar fossa									
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19b. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 20, 1980 to Feb. 15, 1985 , that the (we) lost saw the deceased alive on Feb. 15, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harold F. McCann M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-16-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD F. MCCANN				22e. ADDRESS 3355 16th St. N.W. WASH. D.C. 20010					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 19, 1985		23c. NAME OF CEMETERY OR CREMATORY Long Island National Cem. Farmingdale, New York			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME The Hysong Co. 1300 N St. N.W. Washington, D.C.				ADDRESS 1300 N St. N.W. Washington, D.C.		25a. DATE REC'D. BY REGISTRAR FEB 12 6 1985		25b. REGISTRAR'S SIGNATURE G. Davidson-Randall	

1895, 1896

78

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

Figure 1. The effect of the concentration of the inhibitor on the rate of polymerization of α -methylstyrene in the presence of SnCl_4 at 25°C .

CC-0-3-55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Frances Preftakes					2a. DATE OF DEATH MONTH DAY YEAR February 23, 1985		2b. HOUR 3:05 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 7 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurant		12b. KIND OF BUSINESS OR INDUSTRY Owner		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.					13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Panagiotti Manolakis					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Panagiota Gkrouzelis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 221-01-1881		17. INFORMANT ADDRESS Nicholas Preftakes, Same as item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Brain Syndrome									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED, (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) N/A						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 5-10 19 80 , to 2/23 19 85 , that (I) (we) lost saw the deceased alive on 2/19 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Geo T. Economos M.D.						22c. DATE SIGNED 2/25/1985		22d. PHYSICIAN'S NAME (TYPE OR PRINT) George T. Economos		
22e. ADDRESS 2141 K St. N.W. Washington, D.C. 20037										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/27/1985		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.						25a. DATE REC'D. BY REGISTRAR (S) REGISTRAR'S SIGNATURE MAR 01 1985				

20:

Washington, D.C.

Executive

Director

Washington, D.C. 20540

Washington, D.C. 20540

Washington, D.C. 20540

Washington, D.C. 20540

Washington, D.C. 20540

Washington, D.C. 20540

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Washington, D.C. 20540

Washington, D.C. 20540

WASHINGTON

WASHINGTON

8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AGNES MARIE PREZIOTTI		2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 1 1985	
2b. HOUR 9:33 a.m.			
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR AUGUST 25 1909	
6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR IF UNDER 23 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PUERTO RICO	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE VIRGINIA		13b. CITY OR TOWN ARLINGTON	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13d. STREET ADDRESS / ZIP CODE 3000 SPOUT RUN PARKWAY 22201			
14. FATHER'S NAME FIRST MIDDLE LAST FERDINAND JOHANSEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FULGENCIA DELEON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 577-01-0505	17. INFORMANT ADDRESS RICHARD PREZIOTTI, 1630 N. KIRKWOOD ROAD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 29 , 19 84 , to FEBRUARY 1 , 19 85 , that (I) (we) last saw the deceased alive on FEBRUARY 1 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) H. P. LIEBERT, LT, MC, USNR		22c. DATE SIGNED 1 FEB 85	
22d. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/5/85	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington VA.
24. FUNERAL DIRECTOR Murphy Funeral Home/4510 Wilson Blvd. Arlington, VA		25. DATE REC'D. BY REGISTRAR FEB 6 1985	
26. REGISTRAR'S SIGNATURE <i>Julia DeLeon-Randall</i>			

①
END MATRIAL

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) CHARLES O'BRIEN PRINDLE					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 26 1985			2b. HOUR 11:20 ^a M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 20 1931			6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. NAVY			12b. KIND OF BUSINESS OR INDUSTRY DEFENSE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4802 SLIGO LANE 22003				
13a. STATE VIRGINIA		13b. COUNTY FAIRFAX		13c. CITY OR TOWN ANNANDALE							
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES H. PRINDLE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARJORIE T. O'BRIEN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1953-present		17. INFORMANT ADDRESS LEOTA J. PRINDLE, 4802 SLIGO LANE, ANNANDALE, VA							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC COLON CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 19 , 19 85 , to FEBRUARY 26 , 19 85 , that (I) (we) last saw the deceased alive on FEBRUARY 26 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William A. Delacey</i>						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 27 Feb 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. A. DELACEY, LT, MC, USNR						22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/1/85		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL			23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON Va.			
24. FUNERAL DIRECTOR NAME Marshall's Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR MAR 1 1985					
25b. ADDRESS 4217 9th Street, N.W. Washington, DC											

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AMAZA J. REID			2a DATE OF DEATH MONTH DAY YEAR Feb. 22 85			2b HOUR MIN. 6:30 PM	
3 SEX FEMALE		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Aug 31 1911		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 73	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Winton, N.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice President	
12b KIND OF BUSINESS OR INDUSTRY Auto dealer		13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring	
14 FATHER'S NAME FIRST MIDDLE LAST Samuel Joyner		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Brown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 9207 Watson Road 20910	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 075-22-0639		17 INFORMANT ADDRESS Jill Reid, daughter, 9207 Watson Rd, Silver Spr. Md.			

18 CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c.)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary EmbolismAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**1 hour**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Metastatic Carcinoma****1 year**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:22 P.M. 2/22 85		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) 2/22 85			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE 7500 Hammer Pkwy Greenbelt MD			
22a I certify that (I) (this hospital) attended the deceased from 2/22 85 to 2/22 85 , that (I) (we) last saw the deceased alive on 2/22 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE GARRIE JARRE, MD				DEGREE ATTENDING PHYSICIAN		22c DATE SIGNED 2/23/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) GARRIE JARRE, MD				22e ADDRESS 7500 Hammer Pkwy Greenbelt MD			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 27 Feb 1985		23c NAME OF CEMETERY OR CREMATORY 1st Bapt. Ch. of Winton		23d LOCATION CITY OR TOWN COUNTY STATE Winton, North Carolina	
24 FUNERAL DIRECTOR NAME McGuire F.H.				25 DATE REC'D. BY REGISTRAR FEB 27 1985		25b ADDRESS 17400 Ga. Ave, NW.	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE MEDICAL EXAMINER. GIVE PAGES 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mary Ann Reilly										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2 13 1985	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV 7, 1931		6. AGE (IN YEARS) LAST BIRTHDAY 53 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 2 13 1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CREDIT CLERK		12b. KIND OF BUSINESS OR INDUSTRY MONT. WARD	
13a. STATE MARYLAND		13b. CITY OR TOWN MONTGOMERY		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 3906 MORRELL CT 20895			
14. FATHER'S NAME FIRST MIDDLE LAST J. MORGAN MATTHEWS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BROZTOWSKI				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)			
16a. SOCIAL SECURITY NO. 577-40-6164				17. INFORMANT DAUGHTER				ADDRESS 8980 MAPLE STREET WASH., D.C. 20012			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraabdominal hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? BODY ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										TITLE (SPECIFY) Assistant MEDICAL EXAMINER	
ACTUAL SIGNATURE Margarita A. Korell				DATE SIGNED 2/13/85							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St. Balto. MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 2/15/85				23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN			
23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.				24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR FEB 19 1985			
25b. REGISTRAR'S SIGNATURE J. Davidson-Randall				25c. ADDRESS 500 UNIV. BLVD., SILVER SPRING, MD. 20901							

NO. 202 COLLECTION

1900 JAN 10

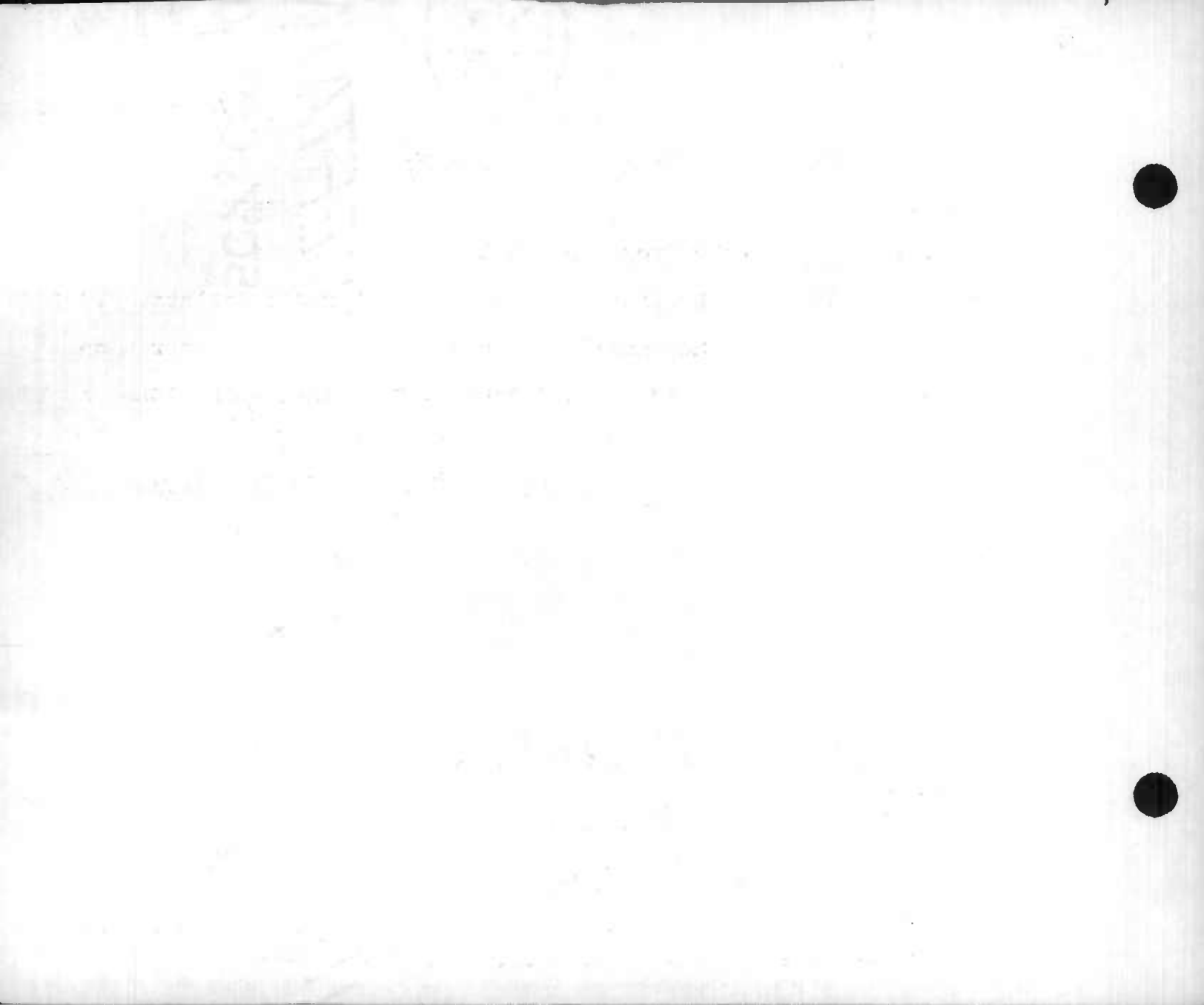
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 05773				
1. DECEASED NAME (TYPE OR PRINT) HELEN MYRTLE RESNICKY					2a. DATE OF DEATH MONTH FEB DAY 11 YEAR 1985 2b. HOUR 11:09 AM				
3. SEX Female		4. RACE Cauc		5. DATE OF BIRTH MONTH 3 DAY 13 YEAR 01		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 7. IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STREET ADDRESS / ZIP CODE Box 415 LaPlata, Md. 20646				
13a. STATE Md.		13b. COUNTY PG		13c. CITY OR TOWN LaPlata		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST Paul MIDDLE LAST McConnell		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST Barraumon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b. SOCIAL SECURITY NO. 217 44 0097		17. INFORMANT ADDRESS John W. Resnick (Husband) Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c; and 1d, 1e, and 1f. APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH)									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic Shock 5 days									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) General Coronary Artery disease yrs									
DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/1/85 to 2/11/85 that (I) (we) last saw (I) (we) (did) (did not) the body after death. 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE ALAN T. KERMAIER, MD		22c. ADDRESS 10313 Georgia Ave. S.S., Md.		22d. DATE SIGNED 2/11/85		22e. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN T. KERMAIER, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/15/85		23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven		23d. LOCATION CITY OR TOWN S.S. COUNTY Mont. STATE Md.		25a. DATE RECEIVED BY REGISTRAR FEB 19 1985 25b. REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.									

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Charles T. Rhodes				February 25, 1985			
3 SEX Male				4 RACE White			
5. DATE OF BIRTH MONTH DAY YEAR Dec 25, 1929				6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS			
7b. CITIZEN OF WHAT COUNTRY? U.S.A.				9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Olney				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired construction				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Howard			
13c. CITY OR TOWN Clarksville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 5857 Trotter Road 21029							
14 FATHER'S NAME FIRST MIDDLE LAST late Guy A Rhodes				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clulla Burdette Sigman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 232 34 4665			
17 INFORMANT ADDRESS Mrs Mary L Rhodes 5857 Trotter Rd 21029							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>spasms</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Auto-decidual fistula</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION 1-23-85				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Auto-decidual fistula			
19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-23</u> , 19 <u>85</u> , to <u>2-25</u> , 19 <u>85</u> , that (I) <u>lost</u> saw the deceased alive on <u>2-25</u> , 19 <u>85</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.							
22b. SIGNATURE <u>Michael D. Sulkowicz</u>				22c. DATE SIGNED 2-26-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL D SULKOWICZ				22e. ADDRESS 18111 Prince Philip Dr Olney Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE March 1, 1985			
23c. NAME OF CEMETERY OR CREMATORY Crestlawn				23d. LOCATION CITY OR TOWN COUNTY STATE Howard County			
24 FUNERAL DIRECTOR NAME Harry H Witzke				25a. DATE REC'D. BY REGISTRAR FEB 27 1985			
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson Randall</u>							

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1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

2. The second part of the paper is devoted to a discussion of the specific properties of the atom. It is shown that the specific properties of the atom are determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

3. The third part of the paper is devoted to a discussion of the experimental results of the theory of the structure of the atom. It is shown that the experimental results of the theory of the structure of the atom are in good agreement with the predictions of the theory of quantum mechanics.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Abraham Avon John Richardson										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2/ 27/ 1985	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 21 46		6. AGE (IN YEARS) LAST BIRTHDAY) YRS. 38		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2/ 27/ 1985		7b. HOUR M 5:00 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10. CITY OR TOWN OF DEATH Olney				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker Helper		12b. KIND OF BUSINESS OR INDUSTRY Ottenbergs	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS JMD Montgomery Wheaton YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 3210 Kayson St. 20906											
14. FATHER'S NAME FIRST MIDDLE LAST Charles Richardson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Berrin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES No				16b. SOCIAL SECURITY NO. 579-56-5752		17. INFORMANT Carolyn Richardson				ADDRESS 3210 Kayson St. Wheaton, MD 20906	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intravenous Narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 2/28/85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/5/85		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover Prince George's MD			
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019						25a. DATE REC'D. BY REGISTRAR MAR 05 1985					



ROLLING FURNACE, INC.
4300 HUNT PLACE, N.E.
WASHINGTON, D.C. 20010



NOT FOR
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705-21-1100

Caroline Richardson
Houston, TX

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner and the pathologist must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 7 7 0
05776

FOR
1- STATE
REGISTRAR

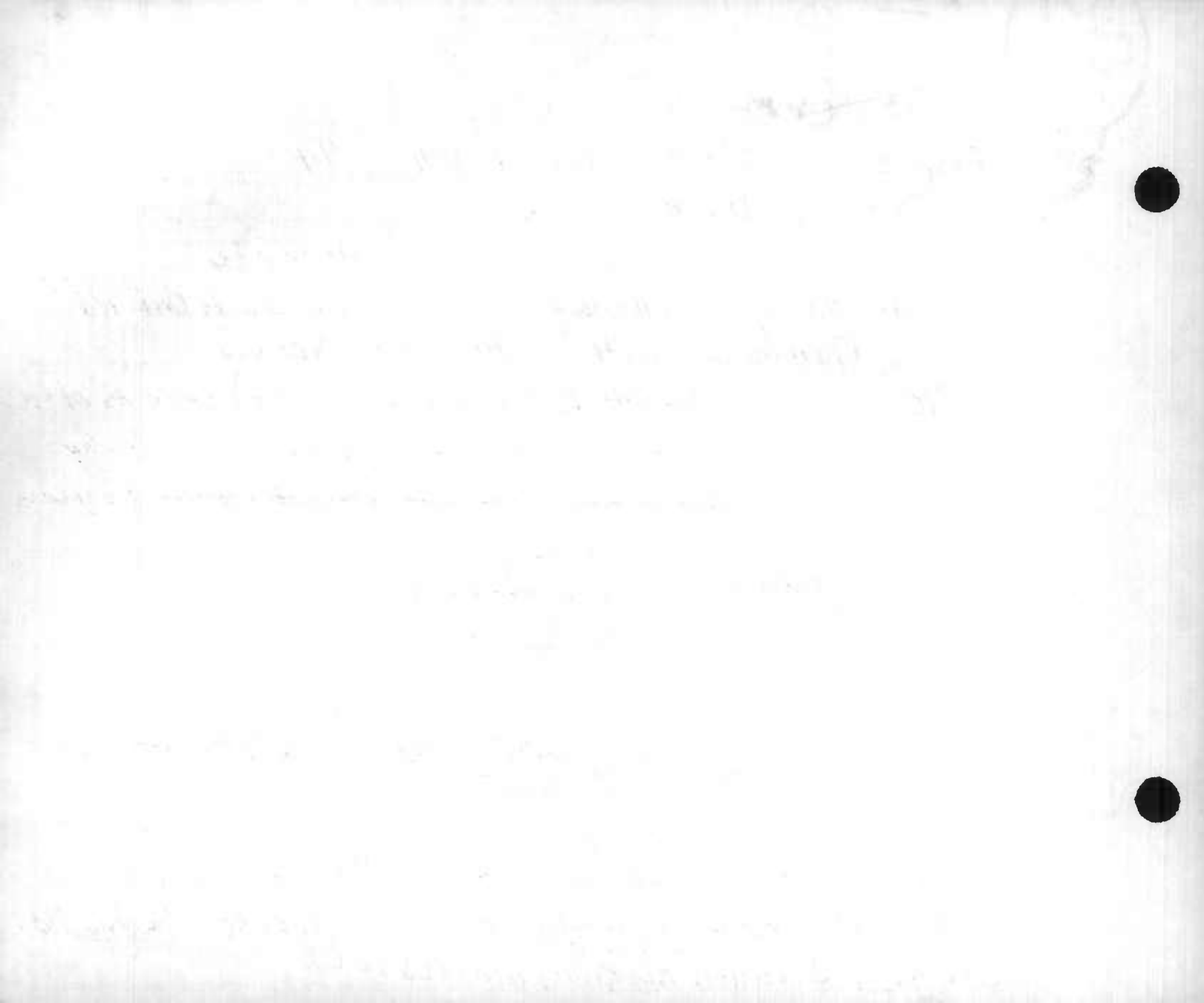
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mabel F Ricks			2a. DATE OF DEATH MONTH DAY YEAR 2-7-85			2b. HOUR 2:08 AM				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Garthersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 15620 Quince Orch. Rd. 20878	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Armintha Norris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-34-3917		17. INFORMANT ADDRESS Sharon Frazier (niece) same as above					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cerebral Vascular Disease 15 years			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Purpheral Arteriosclerosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/1/19 63 to 2/7/19 85, that (we) last saw the deceased alive on 2/6/19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert C. Macon		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. Macon for S.N. Jones		22e. ADDRESS 809 Viers Mill Rd. Rockville, Md 20851					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-12-85		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.		23d. LOCATION Rockville, Md	
24. FUNERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Wash. St. Rockville, Md.		25a. DATE REC'D. BY REGISTRAR FEB 13 1985	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 05777

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William W. Robertson			2a. DATE OF DEATH MONTH DAY YEAR Feb. 5 1985		2b. HOUR 9:20P M		
SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 26, 1903		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner/Operator		12b. KIND OF BUSINESS OR INDUSTRY Cleaning Laundry-Dry	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William W. Robertson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Blamire		13e. STREET ADDRESS 3503 S. Leisure World Blvd.		13f. ZIP CODE 20906	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Wife) Elizabeth Robertson, World Blvd, Silver Spring		ADDRESS 3503 S. Leisure	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Acute Myocardial Infarction**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

atrial fibrillation, Dementia, Spinal Stenosis.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 2, 1985 to Feb 5, 1985 that (I) (we) lost saw the deceased alive on 2-5-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Oliver J. Lawless MD				DEGREE MD		22c. DATE SIGNED 2-6-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OLIVER J. LAWLESS MD				22e. ADDRESS LEISURE WORLD MEDICAL CENTER,			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE February 7, 1985		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Avenue, Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR FEB 8 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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LIBRARY
1100 EAST 58TH STREET
CHICAGO, ILL. 60637

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CHIEF OF

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 7 7 8

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELsie P. ROBINSON			2a. DATE OF DEATH MONTH DAY YEAR FEB. 1 1985		2b. HOUR 12:40 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 1 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13523 Westwind Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 13523 Westwind Drive 20904	
14. FATHER'S NAME FIRST MIDDLE LAST William Frederick Strasser		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Imogene Moxley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Elsie R. Trivett-dau-13244 Glenhill Rd. Silver Spring, Md. 20904	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years					years
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) diabetes mellitus, uremia, atrial fibrillation					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 19 81 to Feb 1 19 85, that (II) (we) last saw the deceased alive on Jan 28 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Walter R. Ehrmanbaurt		DEGREE M.D.		22c. DATE SIGNED 2/1/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter R. Ehrmanbaurt		22e. ADDRESS 11125 Rockville Pike, Rockville Md		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 2, 1985	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.	
24. FUNERAL DIRECTOR Hines-Rinaldi Funeral Home		11800 N.H. Ave. Sil. Spr. Md. 20904		25a. DATE REC'D. BY REGISTRAR FEB 1 1985	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, show any injury, or other traumatic event, the medical examiner, coroner, or medical investigator should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 05779	
FOR 1- STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
SARAH ROGAN					FEB. 2 1985					1:50 P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
FEMALE		CAUCASIAN		Aug. 1, 1892		92 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		SYLVAN MANOR NURSING HOME				Saleswoman (Ret.)		Retail Clothing			
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE		
Maryland					Montgomery		Bethesda		5149 Dudley Lane; 20814		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
(Unknown)					Chartoff					Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO					068-20-2925		Gary Hayes; 5149 Dudley Lane; Bethesda, Md. 20814				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN (a) AND (b) AND (b) AND (c)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Respiratory Arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Stroke in the Cardiovascular System</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Yours</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
				HOUR A.M. MONTH DAY YEAR		P.M. 19					
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <i>Aug 6</i> 19 <i>81</i> to <i>Feb 2</i> 19 <i>85</i> , that (1) (we) lost <i>Aug 16</i> 19 <i>81</i> , and that in <i>our</i> (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not lose the body after death, so state.)											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
<i>Beth Ann Aronson, M.D.</i>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			Feb. 2, 1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Beth Ann Aronson, M.D.						3720 Farnsworth Ave. Ken. Md. 20155					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
BURIAL			2/6/85		Britton Road Cemetery			City or Town County State			
								Monroe County; Rochester, N.Y.			
24. FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
DANILANSKY-GOLDBERG MEMORIAL CHAPELS						FEB 06 1985			<i>Julia Davidson-Randall</i>		
1170 ROCKVILLE PK. ROCKVILLE MD.											

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN J. ROHRER, SR					2a. DATE OF DEATH MONTH DAY YEAR FEB. 3, 1985	
3. SEX male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 29, 1901		
6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.		10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL		
12a. USUAL OCCUPATION (IF DECEASED WAS ENGAGED IN LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT		13. STREET ADDRESS 3103 BECKENHAM CT. 20906		
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE REDSECKER ROHRER M.D.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELAIDE GROHEN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
17a. SOCIAL SECURITY NO. 190-09-4714		17b. INFORMANT (DAUGHTER) NANCY R. DORSCH		17c. ADDRESS 9608 ACCORD DR., POTOMAC, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac event Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Myocardial Infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Congestive Heart Failure</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (this hospital) attended the deceased from 1-12-85 to 2-3-85, that (the) saw the deceased alive on 2-2-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE A. Rotsztein		
22c. DATE SIGNED 2-3-85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. ROTSZTEIN		22e. ADDRESS 3701 Reservoir Blvd S. Spring Md 20906		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2/3/84		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		
23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA		24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC.		25a. DATE REC'D. BY REGISTRAR FEB 5 1985		
25b. REGISTRAR'S SIGNATURE Sheila Gordon-Hendall		1804 T ST., N.W., WASH., D.C. 20009				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

05781

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma - Ronald			2a. DATE OF DEATH MONTH DAY YEAR 02 25 85			2b. HOUR 2018			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 21, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 2 1 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Health Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Mont.		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 3003 BONVIEW LANE / 20906			14. FATHER'S NAME FIRST MIDDLE LAST Israel S. Silverberg			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS SEYMOUR J. RONALD (SON) SAME AS #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Intracerebral DUE TO, OR AS A CONSEQUENCE OF (c) Intracerebral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH 1 day year year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from above (I) (we) (did) (did not) view the body after death. 19 2, to date 19, that (I) (we) last saw the deceased alive on 3/25/85 and that in my (our) opinion death occurred on the date and hour and from the causes stated.									
22b. SIGNATURE THOS B. WARD, M.D.			22c. DATE SIGNED 2/25/85			22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOS B. WARD, 6116 ROBIN WOOD, BETHESDA, MD 20817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE Feb. 26, 1985		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.CO., MARYLAND		
24. FUNERAL DIRECTOR NAME ADDRESS CHAMBERS FUNERAL HOME SILVER SPRING, MD.					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANCIS S. RONALDS			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 18, 1985		2b. HOUR MIN. 2:55 PM						
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 28, 1897		6. AGE (IN YEARS LAST BIRTHDAY) YRS 87		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL NURSING CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HISTORIAN		12b. KIND OF BUSINESS OR INDUSTRY U.S. PARK SVC.			
13a. STATE MD			13b. COUNTY WASHINGTON, D.C.		13c. CITY OR TOWN WASHINGTON, D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5528 BROAD BRANCH ROAD, N.W. 20015		
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL RONALDS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET SPRING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) YES WW I			16b. SOCIAL SECURITY NO. 135-30-1674		17. INFORMANT ADDRESS FRANCIS S RONALDS, JR. SAME AS ITEM #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RECURRENT ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>11/2, 1981</u> , to <u>2/18/1985</u> , that (I) (we) last saw the deceased alive on <u>2/18/1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23a. SIGNATURE <i>[Signature]</i>					DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>					23c. DATE SIGNED 2/19/85	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) JACK KLEH, M.D.					23d. ADDRESS 1145 19TH ST., N.W., WASHINGTON, D.C. 20036						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 2/19/85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA			
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC.					25a. DATE REC'D. BY REGISTRAR FEB 20 1985						
1804 T ST., N.W., WASHINGTON, D.C. 20009					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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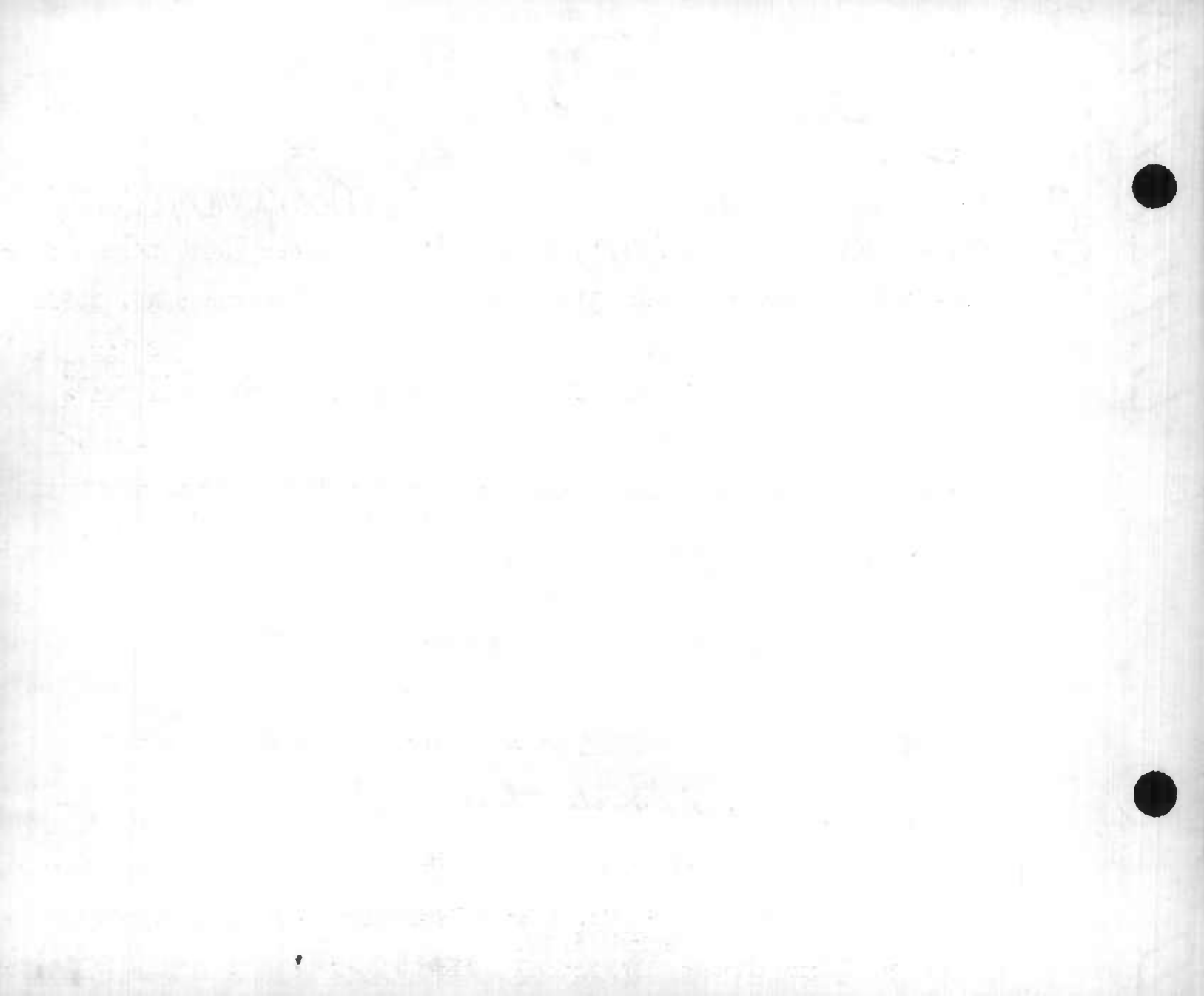
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Jean Rubin</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2-16-85</i>		2b. HOUR <i>4:38 AM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 5, 1908</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Manager (Ret)</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Liquor Store</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Rockville</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>6121 Montrose Rd. 20852</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Max Rubin</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rebecca Sklar</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>579-09-7658</i>		17. INFORMANT <i>Rockville, Md., 20853 Ivan Silverman; 14821 Bauer Drive</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2/5/85</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic obstructive airway</i>								
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Disease</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>3/1/85</i> , 19 <i>85</i> , to <i>3/1/85</i> , 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>3/1/85</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Robert L. Martinez (Dr.) Peter Scher</i> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <i>2/16/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ELBA J. MARTINEZ, M.D.</i>				22e. ADDRESS <i>8808 HIDDEN HILLS DR. - POTOMAC, MD.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2-17-1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Adelphi, Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Danzansky-Goldberg Chapels; 1170 Rockville Pike</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 20 1985</i>				
25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>								

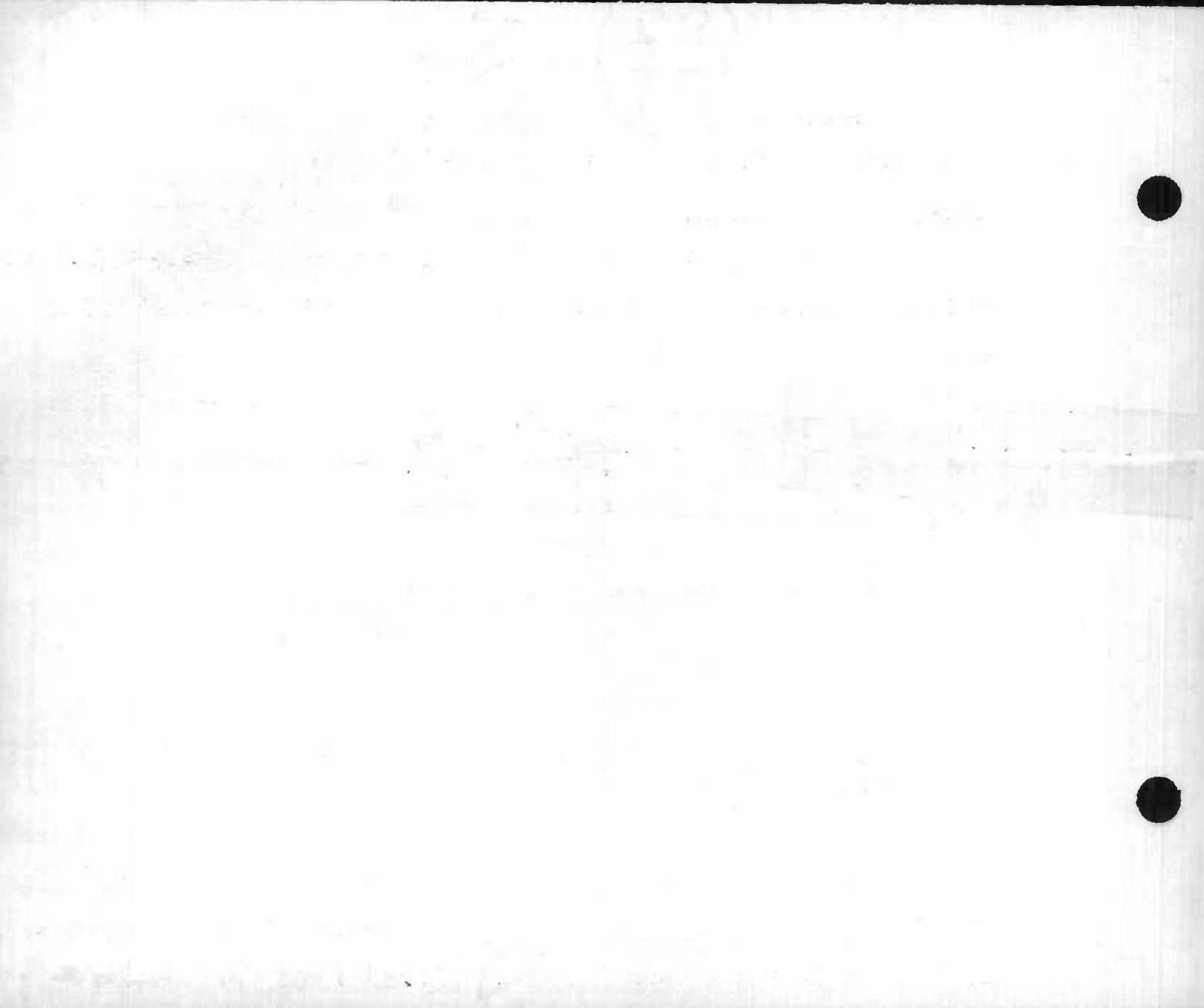


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 202-343-7000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1- FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA RUDMAN				2b. HOUR 10⁵⁰ P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 24, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleswoman (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY Ladies Cloth-	
13a. STATE Maryland				13b. CITY OR TOWN Montgomery		13c. STREET ADDRESS / ZIP CODE 14508 Homcrest Road (20906)	
14. FATHER'S NAME FIRST MIDDLE LAST Hyman Hubberman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Fox			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 123-18-3263		17. INFORMANT ADDRESS Kensington, Md. 20855	
				Sarene Tabershaw: 3916 Spruell Drive;			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY Bilateral Pneumonia							
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a Atherosclerotic Cardiovascular Disease							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — 1/31 85 2/1 85			
22a. I certify that (I) (this hospital) attended the deceased from 2/1 85 to 2/1 85 , that (we) lost saw the deceased alive on 2/1 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) and could not view the body after death.							
22b. SIGNATURE Raymond Bass				DEGREE MD		22c. DATE SIGNED 2/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond Bass				22e. ADDRESS 3925 Ferrara Dr Wheaton, Md 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/3/85		23c. NAME OF CEMETERY OR CREMATORY Dalton Jewish Cemetery; Dalton, Pennsylvania		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHPLS.				25a. DATE REC'D. BY REGISTRAR FEB 07 1985			
1170 Rockville Pike; Rockville, Md. 20854				25b. REGISTRAR'S SIGNATURE Julia Davidson Rendell			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, no autopsy, injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) - Francis H. Rueth			2a. DATE OF DEATH MONTH DAY YEAR 2/17/85		2b. HOUR 11:20 AM						
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 1, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Binder		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12733 Robindale Drive 20853			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph F. Rueth				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie V. Blain							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-38-6290		17. INFORMANT ADDRESS Minnie J. Rueth, same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15'	
										72 hr	
										72 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Alz. M., Organic Brain Syndrome, Bronchitis, ASHOC CHZ</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/17/85</u> to <u>2/17/85</u> , that (I) (we) lost saw the deceased alive on <u>2/17/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Stephen N. Jones, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/17/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 809 Viers Mill Road Rockville, Maryland 20850							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 20, 1985		23c. NAME OF CEMETERY OR CREMATORY Neelsville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Germantown, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850						25a. DATE REC'D. BY REGISTRAR FEB 21 1985		25b. REGISTRAR'S SIGNATURE			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be called on to file a report.

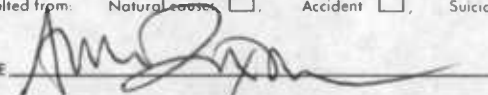
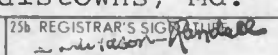
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MARGARET C SABIA					2a. DATE OF DEATH MONTH DAY YEAR Feb 28 1985	
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1898		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		6. AGE (IN YEARS LAST BIRTHDAY) YRS 86		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Court Officer		12b. KIND OF BUSINESS OR INDUSTRY County Courts		13a. STREET ADDRESS / ZIP CODE 10700 Shelley Court/20896		
14. FATHER'S NAME FIRST MIDDLE LAST Charles V. McNulty		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Lynn		13b. CITY OR TOWN Garrett Park		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 180-32-9544		17. INFORMANT ADDRESS Gordon Cavanaugh same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) coronary heart failure, right ventricle						
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic changes						
DUE TO, OR AS A CONSEQUENCE OF (c) 9 days						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from June 19, 76 , to 2-28 , 19 85 , that (1) (we) lost saw the deceased alive on 2-28 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.						
22b. SIGNATURE B. West		DEGREE MD		22c. DATE SIGNED 2-28-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernard H. Ostrow, M.D.		22e. ADDRESS 5225 Pooks Hill Road Bethesda, Maryland 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 4, 1985		23c. NAME OF CEMETERY OR CREMATORY St. Denis Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Havertown, Pennsylvania		24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814				
25a. DATE REC'D. BY REGISTRAR MAR 5 1985		25b. REGISTRAR'S SIGNATURE G. Davidson-Randall				

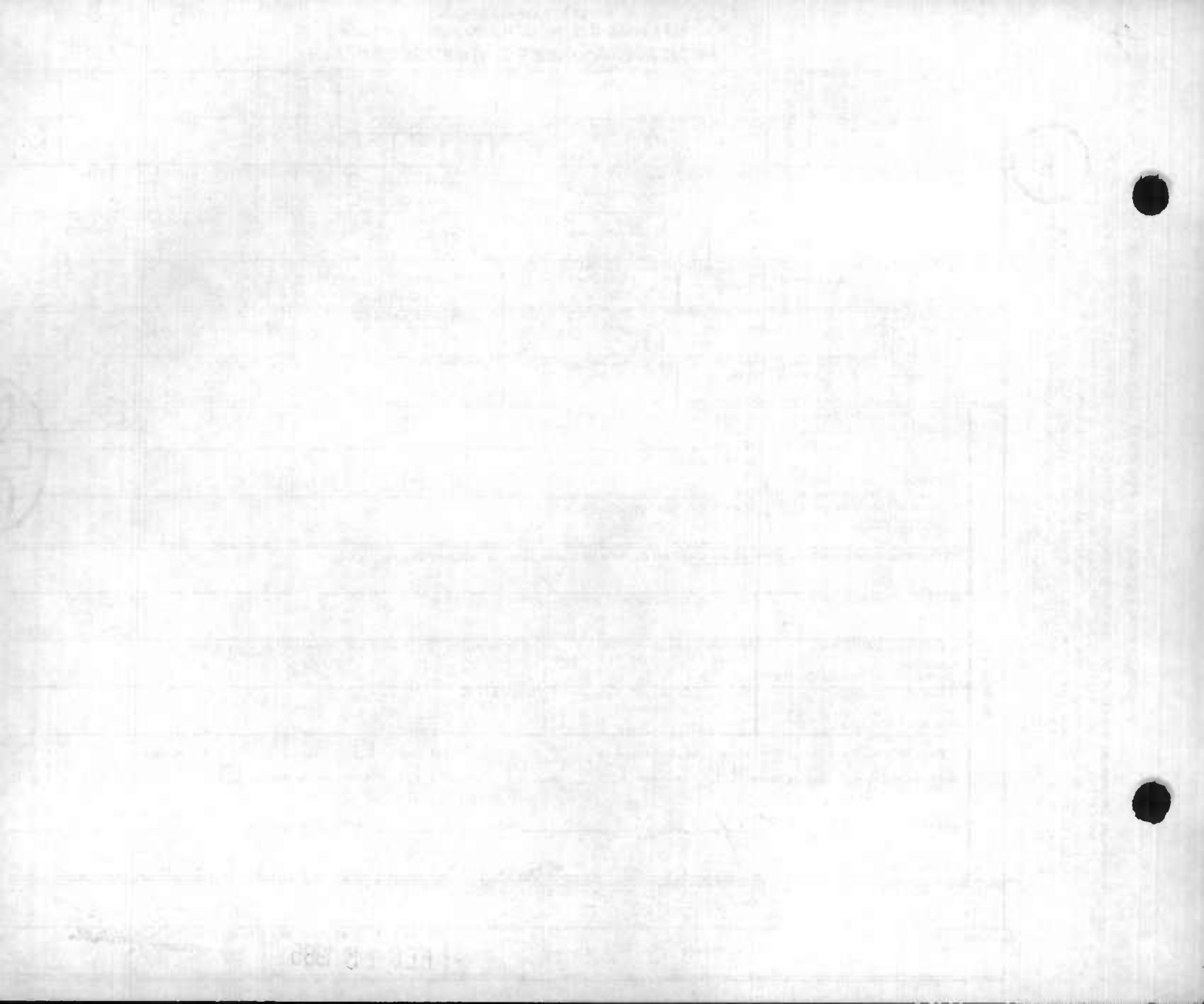


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Tajudeen (Thaudeen) Saliu										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 18 1985
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 30 55	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 29	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 29 1985	2d. HOUR 2:20P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nigeria		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Goldmine Road east of Georgia Ave (woods)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
14. FATHER'S NAME FIRST MIDDLE LAST Alhaji Saliu										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
13a. STATE Md.		13b. COUNTY Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5216 Bowley Lane Apt. F				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Taofiki Owolabi 5216 Bowleys La.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of neck DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR est. P.M. 1 18 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown		21f. LOCATION STREET CITY OR TOWN COUNTY STATE unknown						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 1/30/85										
ACTUAL SIGNATURE 		EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St. Balto.MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/12/85		23c. NAME OF CEMETERY OR CREMATORY Islam Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Randalstowns, Md.				
24. FUNERAL DIRECTOR NAME Wm C March F/H ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR FEB 13 1985		25b. REGISTRAR'S SIGNATURE 				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leroy THOMAS Samuels			2a. DATE OF DEATH MONTH DAY YEAR FEB 7, 1985		2b. HOUR 5:30A M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPT 14, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.
10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WILSON HEALTH CARE CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) METEOROLOGIST		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY SAMUELS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAE SEDLAK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-48-2930		17. INFORMANT RUTH COSTA		ADDRESS SAME AS 13 DAUGHTER
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) urosepsis DUE TO, OR AS A CONSEQUENCE OF (b) rectal carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 1 year						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a peripheral neuropathy						
19a. DATE OF OPERATION Feb 4		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED urosepsis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from Oct 1982 to Feb 7 , 19 85 , that (2) we last saw the deceased alive on Feb 4 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Paul Kretling		DEGREE MD		22c. DATE SIGNED 2-7-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Kretling		22e. ADDRESS 2101 Medical Park Drive Silver Spring, MD 20901				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2/8/85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		
23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA		23e. DATE REC'D. BY REGISTRAR FEB 11 1985				
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25b. REGISTRAR'S SIGNATURE Carla Burdick-Hopkins				

BP _____

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

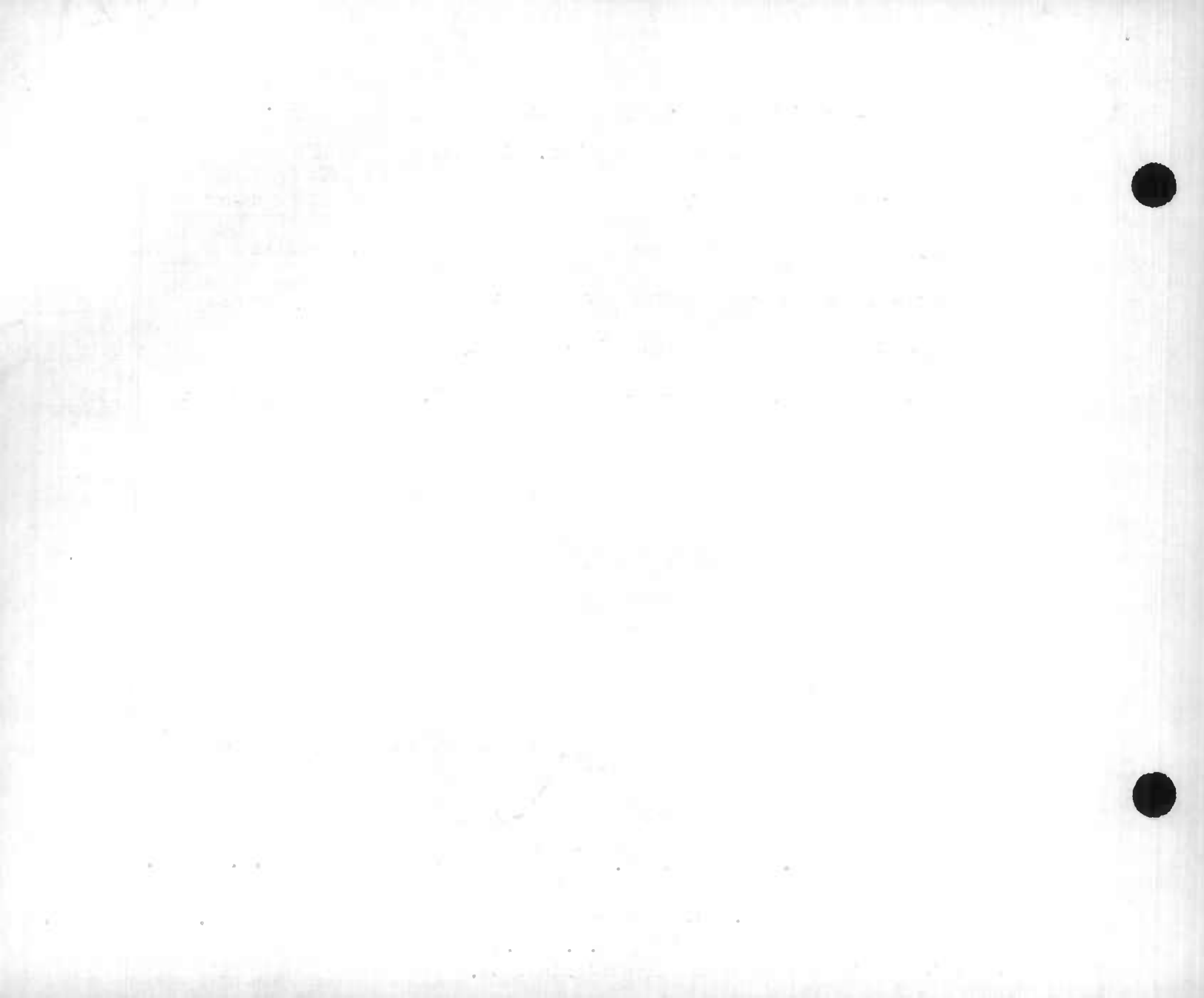
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marion A. Saxton			2a. DATE OF DEATH MONTH DAY YEAR Feb. 21 1985		2b. HOUR 4:28 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 12 1922		
6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			10. CITY OR TOWN OF DEATH Silver Spring			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 11622 Neely Road 20903			
14. FATHER'S NAME FIRST MIDDLE LAST Augustine Glenefsky			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Valukis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS William H. Saxton-husband-(same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOC						
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CANCER						
DUE TO, OR AS A CONSEQUENCE OF (c) CANCER OF OVARY						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. CERTIFY THAT (I) (this hospital) attended the deceased from 10/27/85 to 2/21/85 that (I) (we) last saw the deceased alive on 2/21/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Stanley A. Schwartz MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/22/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley A. Schwartz, MD.		22e. ADDRESS 106 Irving Street, N.W. Wash., DC				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 23, 1985		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.		24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home Silver Spring, Md.				
25a. DATE RECD. BY REGISTRAR FEB 22 1985		25b. REGISTRAR'S SIGNATURE John Anderson				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2/14 19 85										2b. HOUR OF DEATH 5:50 P. M.																																							
1. DECEASED NAME (TYPE OR PRINT) Clifford L. Sayre										2c. DATE PRONOUNCED DEAD 2/14 19 85										2d. HOUR 5:50 P. M.																																							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.																	
10. CITY OR TOWN OF DEATH Silver Spring										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHEMICAL ENGINEER										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. STATE MARYLAND										13b. COUNTY MONTGOMERY										13c. CITY OR TOWN SILVER SPRING										13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										13e. STREET ADDRESS 1415 LADD STREET										20902									
14. FATHER'S NAME FIRST MIDDLE LAST RALPH SAVRE										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN HEREOLD										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES										16b. SOCIAL SECURITY NO. 1918-1959										17. INFORMANT ADDRESS CLIFFORD L. SAVRE, JR. SAME AS 13 SON																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) arteriosclerotic cardiovascular disease and DUE TO, OR AS A CONSEQUENCE OF Parkinson's disease. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8880 Years										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Fracture of left hip.																																							
19a. DATE OF OPERATION 7/18/84										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture of left hip.										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 7/7 1984										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell in nursing home.																																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Nursing home										21f. LOCATION STREET CITY OR TOWN COUNTY STATE Arcola Ave., Silver Spring, Montgomery, Md.																																							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										TITLE (SPECIFY) Deputy																																							
ACTUAL SIGNATURE John S. Rogers										M.D. Deputy										MEDICAL EXAMINER 1919 Seminary Road										DATE SIGNED 2/15/85																													
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.										ADDRESS Silver Spring, Montgomery, Md.										23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE 2/20/85										23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL										23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA									
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS										500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										25a. DATE REC'D. BY REGISTRAR FEB 19 1985										25b. REGISTRAR'S SIGNATURE John S. Rogers																													

John A. Rogers, M.D.

Silver Spring, Montgomery, Md.
1919 Seminary Road

Deputy

2/19/25

Montgomery, Md., Silver Spring, Montgomery, Md.

Nursing home

7/7 84 Fell in nursing home.

Fracture of left hip.

7/18/24

Fracture of left hip.

arteriosclerotic cardiovascular disease and
Parkinson's disease.

Years

acute myocardial disease

Silver Spring

University Nursing Home

Montgomery County

Male White Nov. 23, 1899 65

Clifford

24/25

2/14

x

5:50

5:50

2/14

5:50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 also be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KENNETH GEORGE SCHACHT			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 18 1985		2b. HOUR 3:40 ^a _M
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JUNE 19 1913	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM F. SCHACHT	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVELYN SHEI		13e. STREET ADDRESS / ZIP CODE 1520 CIRCLE DRIVE 21401		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1935-1965	17. INFORMANT ELIZABETH SCHACHT	ADDRESS 1520 CIRCLE DRIVE,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADULT RESPIRATORY DISTRESS SYNDROME			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 17, 1985 , to FEBRUARY 18, 1985 , that (I) (we) lost saw the deceased alive on FEBRUARY 18, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did; (did not) view the body after death.					
22b. SIGNATURE <i>R. L. NEMEC</i>		DEGREE MD		22c. DATE SIGNED 19 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. L. NEMEC, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb 22 1985	23c. NAME OF CEMETERY OR CREMATORY U.S. Naval Academy	23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. MD	25a. DATE REC'D. BY REGISTRAR FEB 21 1985	
24. FUNERAL DIRECTOR NAME Raylor Funeral Chapel-Annapolis, MD		25b. REGISTRAR'S SIGNATURE <i>Davidson Randall</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IDA SCHADLOW					2a. DATE OF DEATH MONTH DAY YEAR 2-10-85				2b. HOUR 6 ³⁰ PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 15, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. IF UNDER 74 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Finisher (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY Clothing			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11616 Regency Drive (20854)				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac							
14. FATHER'S NAME FIRST MIDDLE LAST Morris Chesner					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Sipper						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 071-12-2387		17. INFORMANT ADDRESS Esther Haar; 11616 Regency Drive; Potomac, Md. 20854							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute renal insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dementia - severe (Alzheimer's)</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>one week</u> <u>over one year</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Incontinence (urinary and fecal), Bilateral cataracts</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>8/1/84</u> to <u>2/10/85</u> that (1) (we) lost saw the deceased alive on <u>2/7/85</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>Stanley Cutler, MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>2/11/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>STANLEY CUTLER</u>				22e. ADDRESS <u>6121 MONTROSE ROAD ROCKVILLE, MARYLAND 20852</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>2/12/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Park Cemetery</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Paramus, New Jersey</u>		
24. FUNERAL DIRECTOR NAME <u>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</u>						25a. DATE REC'D. BY REGISTRAR <u>FEB 1 8 1985</u>					
1170 Rockville Pike; Rockville, Md. 20852						25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Elisabeth Scharf					2a. DATE OF DEATH MONTH DAY YEAR 2 8 85 2b. HOUR 10:30 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
12. CITY OR TOWN OF DEATH Rockville		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Center				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. Administrator Pathology		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE New York		13b. COUNTY Nassau		13c. CITY OR TOWN Massapequa		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20 Atwater Place 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Moritz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helene Kohn		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16a. SOCIAL SECURITY NO. 578-44-6487		17. INFORMANT ADDRESS 11758 Erich Scharf; 20 Atwater Pl., Massapequa, NY							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old aneurysm</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr 3 yr									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>old aneurysm</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>11/18</u> , 19 <u>82</u> , to <u>2</u> , 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>2/6/85</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I am) (we) (could not) view the body after death.									
22b. SIGNATURE <u>Deborah B Goldberg</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Deborah B Goldberg				22e. ADDRESS 1106 Spring St, Silver Spring Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2-11-1985		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEMORIAL CHAPEL 1170 Rockville Pike; Rockville, Md. 20852									

Enrollment

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FEB 18 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHERINE WASHINGTON SCHEURER					2a. DATE OF DEATH MONTH DAY YEAR FEB 05 85		2b. HOUR 8:14 P.M.		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH DAY MONTH YEAR OCT 10 09		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL BETHESDA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA 13b. COUNTY NONE				13c. CITY OR TOWN FALLS CHURCH		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM (N) WASHINGTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANET (N) THOMAS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT DONALD BERTRAM SCHEURER		17. ADDRESS 204 GARDEN COURT FALLS CHURCH, VA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA, LEFT LOWER LOBE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 04 FEB 85 , to 05 FEB 85 , that (I) (we) lost saw the deceased alive on 05 FEB 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R.L. Nemecek</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 06 Feb 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.L. NEMEC, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb. 7 1985		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Falls Church, Va.				25a. DATE REC'D. BY REGISTRAR FEB 11 1985		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Rodell</i>			

41887 NO 1100 302

UNITED STATES

NAVY



RECEIVED

NOV 11 1944

11-11-44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Julia Ann Schmitt			2a. DATE OF DEATH MONTH DAY YEAR Feb. 6, 1985			2b. HOUR M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 27, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 11014 Marcliff Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11014 Marcliff Rd. 20852	
14. FATHER'S NAME FIRST MIDDLE LAST William Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Mackessy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 42 3156		17. INFORMANT ADDRESS Thomas J. Schmitt same as 13e					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subacute Heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Valvular Heart Disease</i> DUE TO, OR AS A COMPLICATION OF (c) <i>Aortic Stenosis and Aortic Insufficiency</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>15 years</i> <i>15 years</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR COMPLICATION GIVEN IN PART I: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <i>2/24</i> 19 <i>85</i> to <i>2/6</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>1/26</i> 19 <i>85</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE <i>Blaine J. Fitzgerald</i>					22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>2/7/85</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Blaine J. Fitzgerald					22f. ADDRESS 8218 Wisconsin Ave. Bethesda, Md. 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/9/85		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL HOME Nelson Wheeler Funeral Home, Inc.					25a. DATE REC'D. BY REGISTRAR FEB 11 1985		25b. REGISTRAR'S SIGNATURE <i>Richard R. Rouse</i>			
1331 Rockville Pike, Rockville, Maryland 20852										

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS-201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR							
THONGBAI						SCHMITZ		2/4		19		85		2:10		P. M.							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		8. MONTH		DAY		YEAR		2:10		P. M.	
Female		Yellow		NOV. 7, 1939		45 YRS.						2/4		19		85		2:10		P. M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Thailand				Thailand								Montgomery County MD.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring				8600 - 16th Street, #404								Seamstress				Self Employed							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS							
Maryland				Montgomery				Silver Spring				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				8600 - 16th Street, #404							
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST								FIRST MIDDLE LAST															
Lejouw								Satae								Sa Jung Young							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				(IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
N/A				N/A				498-86-6087				Lee Schmitz-husband- (same as 13e)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u>																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																							
(b) <u>undifferentiated carcinoma of the parotid.</u>																3 yrs.							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
None																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY?					
None																		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
				P.M. 19				None															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED											
				Deputy				1919 Seminary Road				2/4/85											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
John S. Rogers, M.D.				Silver Spring, Montgomery, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial				Feb. 8, 1985				Arlington National				Arlington Virginia											
24. FUNERAL DIRECTOR NAME				11800 N.H. Ave.,				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Hines/Rinaldi Funeral Home				Silver Spring, Md.				FEB 7 1985															

7

THOMAS

SCOTT

24

10
10
10

Female Yellow Aug. 7, 1959 45

x

Montgomery County

Silver Spring 8600 - 1st Street, 404

Maryland Montgomery Silver Spring 8600 - 1st Street, 404

Metastatic carcinoma

undifferentiated carcinoma of the parotid. 3 yrs.

None

None

None

x

x

24/85

Deputy
1919 Seminary Road
Silver Spring, Montgomery, Md.

John S. Rogers, M.D.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 05797

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Walter M Scott SR.			2a. DATE OF DEATH MONTH DAY YEAR February 22, 1985			2b. HOUR 4:52 pm	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 4 13		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired URM		12b. KIND OF BUSINESS OR INDUSTRY UKM	
13a. STATE Md		13b. CITY OR TOWN Poolesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 19610 Wootton Ave 20437	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL W SCOTT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE EVANS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.U.H. 079 326137	
17. INFORMANT WALTER M SCOTT, JR.		ADDRESS 19610 WOOTTON AVE POOLESVILLE, MD 20837		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Overwhelming sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Perforated colon</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	

MEDICAL CERTIFICATION

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Constipation, Mega colon</u>			
19a. DATE OF OPERATION 2/22/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal Sepsis	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/22/85</u> 19 <u> </u> , to <u>2/22/85</u> 19 <u> </u> , that (I) (we) lost saw the deceased alive on <u>2/22/85</u> 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Arthur F. Woodward, Jr. MD		22c. DATE SIGNED 2/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur Woodward, Jr., M.D.		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2/24/85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON ARLINGTON VA	
24. FUNERAL DIRECTOR NAME W. C. HILTON		24b. ADDRESS 23111 BEALLSVILLE RD BARNESVILLE, MD		25a. DATE REC'D. BY REGISTRAR MAR 01 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Rodgers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

7

CHIEF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 7 9 8

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Robert M. Selbst</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2-10-85</i>			2b. HOUR <i>11:30 PM</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2-8-99</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County, MD.</i>	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Hosp. Administrator; Monticello</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Shaiya Rabinowitz</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jennie (Unknown)</i>		13e. STREET ADDRESS / ZIP CODE <i>1605 Overlook Drive (20903)</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>156-01-3606</i>		17. INFORMANT ADDRESS <i>Maryland 20903</i> <i>Norman Selbst; 1605 Overlook Dr.; Silver Spring</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Expected massive Myocardial Infarct</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetic Mellitus</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12-29</i> , 19 <i>84</i> , to <i>2-10</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>2-10</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE <i>Norman S. Koual MD</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2-10-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NORMAN S. KOUAL MD</i>		22e. ADDRESS <i>10313 GEORGIA AVE S.S. MD 20902</i>					
23a. BURIAL, CREMATION, REMOVAL SPEC #2 <i>Burial</i>		23b. DATE <i>2/12/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Judean Memorial Gardens, Olney, Montgomery, Maryland</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i>		25a. NAME <i>1170 Rockville Pike; Rockville, Md. 20852</i>		25b. DATE <i>2-10-85</i>		25c. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALEX Shahnazarian			2a. DATE OF DEATH MONTH DAY YEAR 2-14-85			2b. HOUR MIN. 322 p.m.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 13 43		6. AGE YEARS (LAST BIRTHDAY) 41		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iran		7b. CITIZEN OF WHAT COUNTRY? Iran		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Food Chain	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Vahram Shahnazarian			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Genia Ohanian			13e. STREET ADDRESS / ZIP CODE 844 Quince Orchard Blvd. 20878			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-94-6771		17. INFORMANT ADDRESS Aida Shahnazarian same as 13e				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **cardiorespiratory Failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **Myocardial Infarction with hemiparesis 3 days**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Ruptured Basilar aneurysm**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
45 minutes

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

s/r Renal Transplant

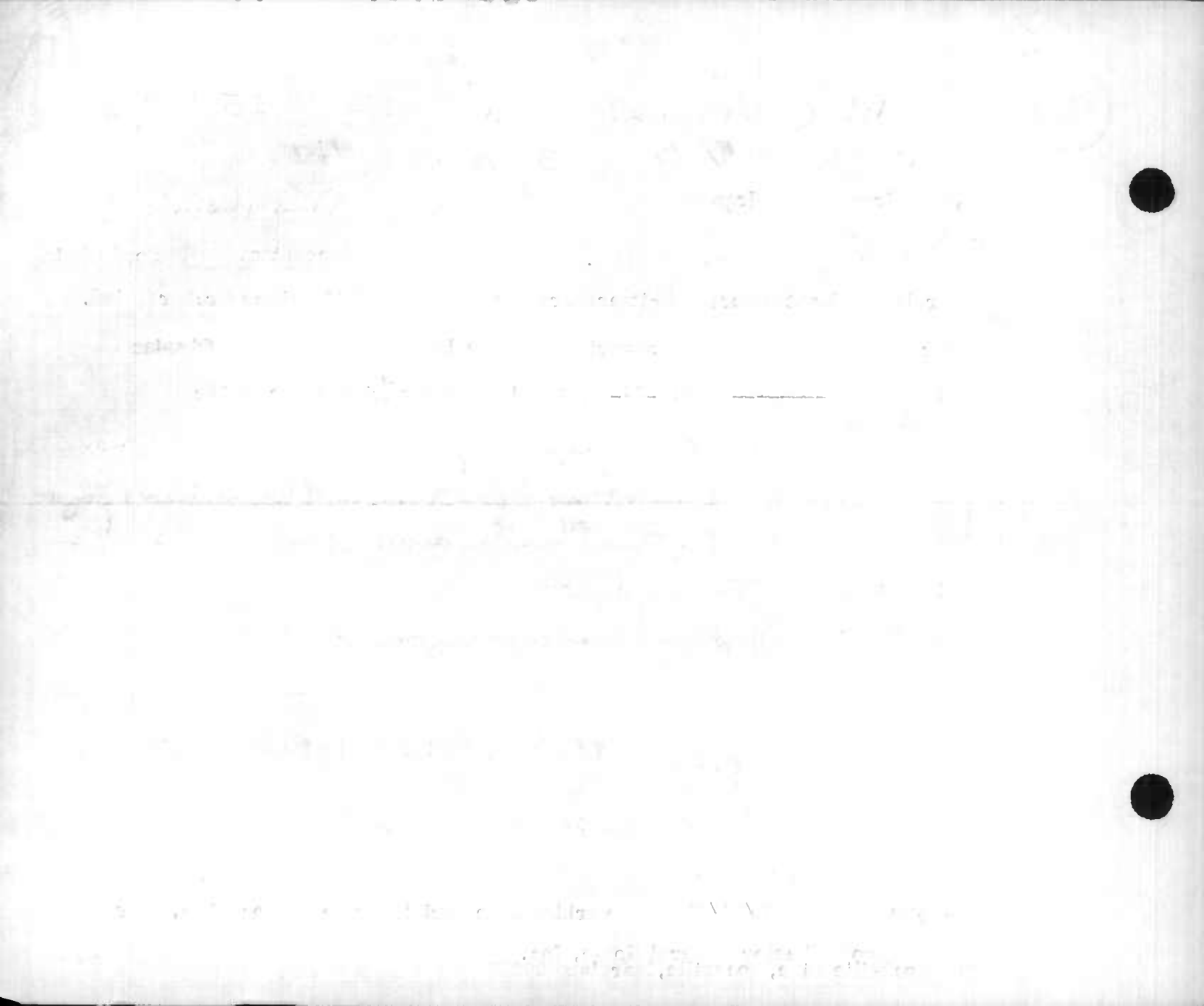
19a. DATE OF OPERATION 9 Feb 85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Basilar aneurysm		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8 Feb , 19 85 , to 14 Feb , 19 85 , that (I) (we) last saw the deceased alive on 14 Feb 85 at 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ronald H. Uscinski				DEGREE MD		22c. DATE SIGNED 14 Feb 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD H. USCINSKI				22e. ADDRESS 7960 OLD GEORGETOWN RD BETHESDA			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/18/85		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR FEB 22 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson	
1331 Rockville Pike, Rockville, Maryland 20852							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Released by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove co-funeral papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
Francis Jackson Short			2/27/85			9:55 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
male		White		07/05/02		82		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Arkansas		U.S.A.				Montgomery MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital				Retired Personnel		C & P Tel.	
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE			
Maryland			Montgomery			10910 Montrose Avenue 20795			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Omar Jackson Short			Martha Dunham						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No			577-01-2813			Chevy Chase, Md. 20815 Thomas M. Raysor 5530 Wisconsin Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intermittent heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>10 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Chronic lymphocytic leukemia; Post-op total left pneumonectomy</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>74</u> to <u>2/27</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/27</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (and) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard M. Huffman MD</u>						DEGREE		22c. DATE SIGNED	
						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
RICHARD M. HUFFMAN, MD.						3301 NEW MEX. AVE, N.W., WASH. D.C.			
23a. BURIAL, CREMATION, REMOVAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Cremation			3/1/85		Cedar Hill Crematory		Suitland, Maryland		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tyson Wheeler, Funeral Home, Inc. 1313 Rockville Pike, Rockville, Md. 20852						MAR 4 1985		<u>Richard M. Huffman</u>	

958

Chronic lymphatic leukemia; 100% total left lymphocytosis
X

BRUNARD M. HICKMAN, M.D., 3301 WOODMAN AVE. N.W., WASH. D.C.
2/21/52
24 2/21 52
2/21/52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
			FIRST MIDDLE LAST Mollie C. Shulsky		MONTH DAY YEAR 02 08 85	
3. SEX Female			4. RACE White		2b. HOUR 2:45AM	
5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
MONTH DAY YEAR April 18, 1907			77 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Piano Teacher			12b. KIND OF BUSINESS OR INDUSTRY Pvt. Lessons			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME NATHAN			15. MOTHER'S MAIDEN NAME LEAH		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
17. INFORMANT Maryland 20852			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> DUE TO, OR AS CONSEQUENCE OF (b) <i>Respiratory Failure</i> DUE TO, OR AS CONSEQUENCE OF (c) <i>Myo-infarct lateral Sclerosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>5 years</i>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Previous myocardial infarction, Myocardial</i>						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>2/19/85</i> to <i>2/8/85</i> , that (I) (we) lost saw the deceased alive on <i>2/19/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Oliver Lawless</i>			DEGREE <i>MD</i>		22c. DATE SIGNED <i>2.8.85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OLIVER J. LAWLESS			22e. ADDRESS LEISURE WORLD MEDICAL CENTER.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/10/85		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gdns.	
23d. LOCATION CITY OR TOWN COUNTY STATE Olney; Montgomery; Maryland			23e. DATE REC'D. BY REGISTRAR FEB 14 1985		23f. REGISTRAR'S SIGNATURE <i>John Davidson-Rodella</i>	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852						

BP

MAY 1962 EDITION

STANDARD

FORM NO. 64

STANDARD FORM NO. 64 MAY 1962 EDITION GSA GEN. REG. NO. 27

STANDARD FORM NO. 64 MAY 1962 EDITION GSA GEN. REG. NO. 27

STANDARD
FORM NO. 64



STANDARD FORM NO. 64 MAY 1962 EDITION GSA GEN. REG. NO. 27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST Ehi SHUSTER				FEB 23, 1985				9:08 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 5, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Religion			
13a. STATE Maryland				13b. CITY OR TOWN Rockville		13c. STREET ADDRESS / ZIP CODE 6121 Montrose Road 20852					
14. FATHER'S NAME FIRST MIDDLE LAST Philip Shuster				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown) Shuster							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577-50-2519		17. INFORMANT ADDRESS Mildred Platt; 6105 Eastview St; Bethesda Md. 20817					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>1 week</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dementia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dementia</u>											
19a. DATE OF OPERATION -				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 2/19/85 to 2/23/85, that (1) we last saw the deceased alive on 2/23/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.											
22b. SIGNATURE Raymond Bass				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-23-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND BASS				22e. ADDRESS 3929 Ferrara Br Wheaton, Md 20906							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-25-1985		23c. NAME OF CEMETERY OR CREMATORY D.C. Lodge Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR FEB 27 1985				25b. REGISTRAR'S SIGNATURE John Davidson			



Cleared by Dr. Mayle(MEO)

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JOHN J. SIMON				2a. DATE OF DEATH MONTH DAY YEAR February 19, 1985		2b. HOUR 3:05A.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 -23 - 1932		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4978 Sentinel Dr. # 504		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor		12b. KIND OF BUSINESS OR INDUSTRY Accounting	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Simon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Renalda		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Korean			
16b. SOCIAL SECURITY NO. 182-24-1070		17. INFORMANT ADDRESS Sumie Simon (See Item # 13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Renal Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>December</u> , 19 <u>81</u> , to <u>February 7</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>February 7</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Richard S. Schulof</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/19/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard S. Schulof, M.D.		22e. ADDRESS 2150 PA Ave. N.W. Wash., DC 20037					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/22/85		23c. NAME OF CEMETERY OR CREMATORY Hillside Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Roslyn, PA	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR FEB 26 1985 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

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(Continued on next page)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

ROBERT WELLS SISSON

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT WELLS SISSON			2a. DATE OF DEATH MONTH 2 DAY 4 YEAR 1985			2b. HOUR 8²² P.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 10 DAY 06 YEAR 99		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (IF BY WORK OF MOST OF WORKING LIFE) Ret. Md. Port. Engineer/Electrician		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD. Montgomery Silver Spring		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 14000 Castle Blvd. Pk. Md.			
14. FATHER'S NAME FIRST Ornstead MIDDLE Sisson		15. MOTHER'S MAIDEN NAME FIRST Ella MIDDLE May LAST Cear		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-03-7966		17. INFORMANT CLARA ELIZ. SISSON	
16c. ADDRESS 14000 CASTLE BLVD. S.S.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) INTRACEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS. 20 MINUTES.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC ATRIAL FIBRILLATION.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/4 19 85 , to 2/4 19 85 , that (I) (we) lost saw the deceased alive on 2/4 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Alan Diamond		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/4/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN DIAMOND				22e. ADDRESS 1106 SPRING ST. SILVER SPRING, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 7-1985		23c. NAME OF CEMETERY OR CREMATORY St. Luke's		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown P.G. Md.			
24. FUNERAL DIRECTOR Arthur Kellers		ADDRESS 254 Carroll St. N. Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR 2/16/85		25b. REGISTRAR'S SIGNATURE Robert Wells Sisson			

BP _____

1

Handwritten text, mostly illegible due to fading and bleed-through. Visible fragments include:

- Top left: "The first..."
- Top center: "The second..."
- Top right: "The third..."
- Middle left: "The fourth..."
- Middle center: "The fifth..."
- Middle right: "The sixth..."
- Bottom left: "The seventh..."
- Bottom center: "The eighth..."
- Bottom right: "The ninth..."

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Emil H. Sloan			2a. DATE OF DEATH MONTH DAY YEAR 2-14-85			2b. HOUR 5:20 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 26 1996		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE NURSING Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Dentist	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE D.C. 13c. COUNTY <input checked="" type="checkbox"/>		13d. CITY OR TOWN WASHINGTON		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE 6127-3RD ST. N.W. 99999	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK SLOAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Regina Bloom				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-44-1196		17. INFORMANT Robert Adams		ADDRESS R.D. LORETTO, PA. 15740	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) General visceral failure DUE TO, OR AS A CONSEQUENCE OF (b) Stroke DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral vascular disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Wks - mos 8 mos Yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 84 to Feb 14 19 85 that (I) (we) last saw the deceased alive on 27 Jan 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Robert T. Kelley				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 14 Feb 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert T. Kelley				22e. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-19-85		23c. NAME OF CEMETERY OR CREMATORY St. Benedict Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Carrolltown Cambria PA.	
24. FUNERAL DIRECTOR NAME Donald J. Gallo ADDRESS W. Main St. Ashville Pa 16613				25a. DATE REC'D. BY REGISTRAR FEB 20 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

Reported To & Released By Dr. John Rogers, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed in the hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other," the funeral director must be notified.

Handwritten text, possibly a date or reference number.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 0 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES W. SLOAN			2a. DATE OF DEATH MONTH DAY YEAR 2 24 85			2b. HOUR 7:37 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 11 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF KNOWN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Excavator	
12b. KIND OF BUSINESS OR INDUSTRY Self-Employed		13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 28328 Kemptown Rd. 20872		14. FATHER'S NAME FIRST MIDDLE LAST William Edward Sloan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel - Fulks	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 218-03-4321		17. INFORMANT Carmen D. Sloan		18. ADDRESS 28328 Kemptown Rd. Damascus, Md. 20872	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiogenic shock

DUE TO, OR AS A CONSEQUENCE OF

(b)

Chronic City Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Arteriosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

COPD, peripheral vascular disease, arrhythmia

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/22 19 85 to 2/24 19 85 , that (I) (we) lost saw the deceased alive on 2/22 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dennis Friedman		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis Friedman, M.D.		22e. ADDRESS 13-15 E. Deer Park Dr, Gaithersburg					

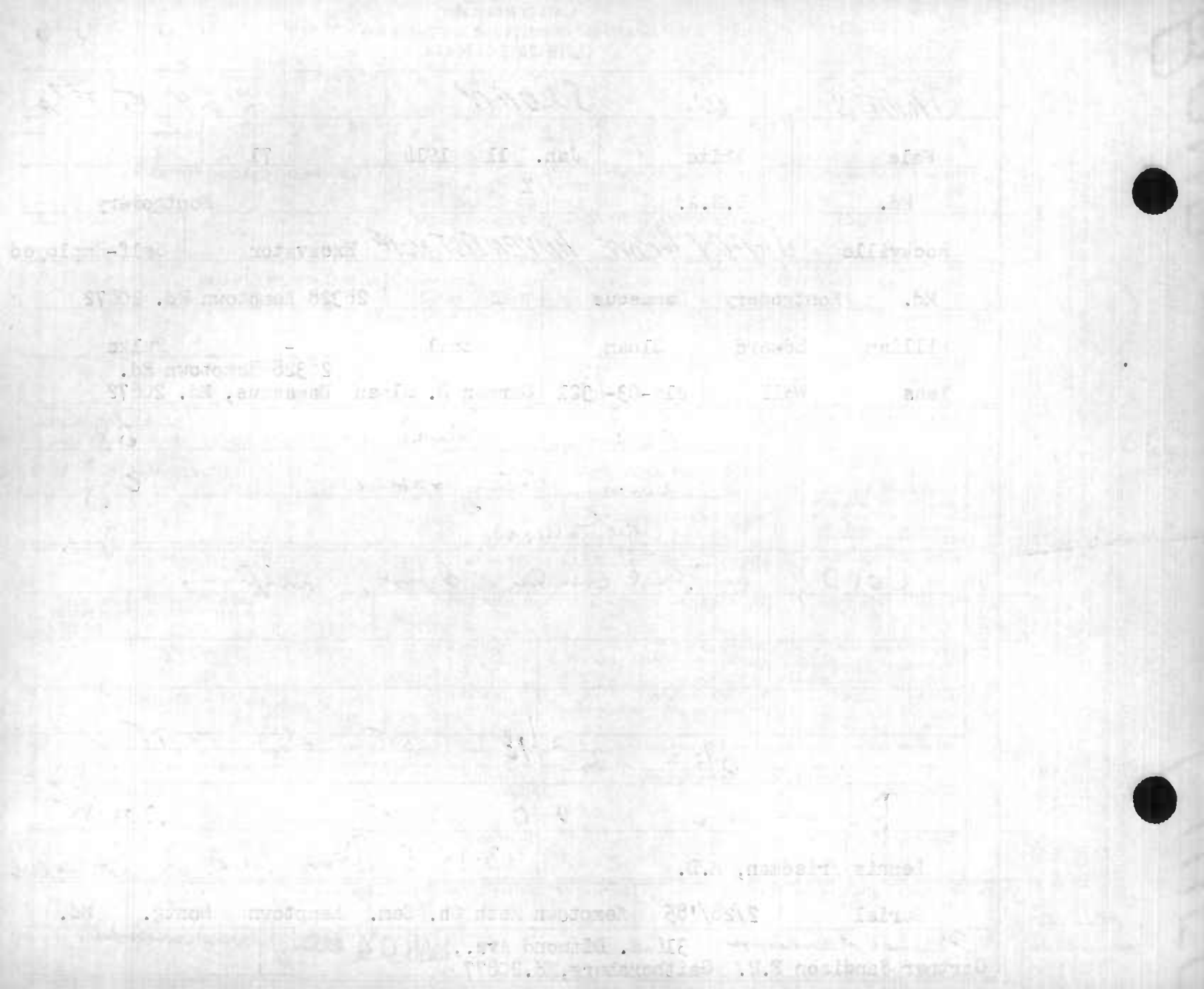
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/28/85		23c. NAME OF CEMETERY OR CREMATORY Kempton Meth Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Kempton Montg. Md.	
24. FUNERAL DIRECTOR Gartner Sandison				25. DATE RECEIVED BY REGISTRAR MAR 04 1985			
26. ADDRESS 316 E. Diamond Ave., Gaithersburg, Md. 20877							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (1))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Alan JAY Smith			2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 2-25 19 85			2b. HOUR M 8:47 a. M				
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 18, 1963	6. AGE (IN YEARS) LAST BIRTHDAY 21 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2-25 19 85				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY CONTROL DATA		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12912 MIDDLEVALE LANE	
14. FATHER'S NAME FIRST MIDDLE LAST THEODORE K. SMITH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINA W. WEISS			16. ADDRESS 12912 MIDDLEVALE LANE, SILVER SPRING, MARYLAND				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-92-1925		17. INFORMANT THEODORE K. SMITH, 12912 MIDDLEVALE LANE, SILVER SPRING, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 2-25 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject inhaled exhaust fumes from auto					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) auto		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Venice Dr. & Bradford Ave., Silver Spring, Montgomery Co., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) Assistant			DATE SIGNED 2-26-85				
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL CREMATION, REMOVAL BURIAL			23b. DATE 2/27/1985		23c. NAME OF CEMETERY OR CREMATORY JUDEAN MEMORIAL GARDENS		23d. LOCATION OLNEY, MONTGOMERY, MARYLAND			
24. FUNERAL HOME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR MAR 01 1985							
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			25c. REGISTRAR'S SIGNATURE <i>[Signature]</i>							



20% COTTON FIBER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must perform an autopsy and complete page 4.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

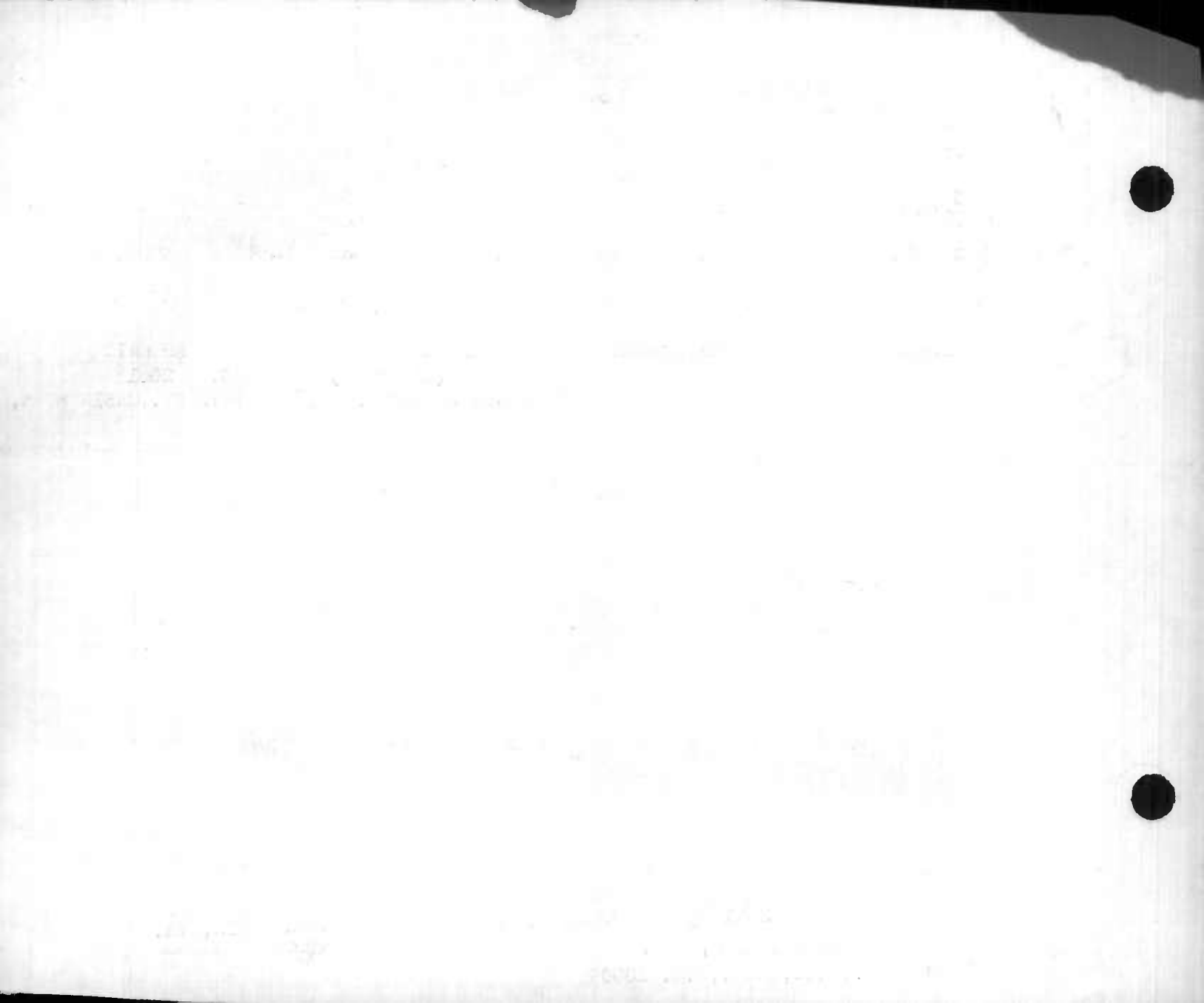
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1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BEATRICE F. SMITH		2a. DATE OF DEATH MONTH DAY YEAR 2-10-85		2b. HOUR 11 45 AM	
3. SEX F	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 5 3 96		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH MONT CO. MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES LADY	
13a. STATE md		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID APPENBAUM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIE MUCHNIC		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 570-09-0195		17. INFORMANT (DAUGHTER) CLARA LINGENFELTER		ADDRESS MD. 20818 6413 78TH ST., CABIN HOHN,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary edema, shock DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 d
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Fever - UTI					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 2/10 19 85 to 2/10 19 85 , that (1) (we) lost saw the deceased alive on 2/10 19 85 , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Peter B. Sherer		DEGREE MD		22c. DATE SIGNED 2/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter B. Sherer MD		22e. ADDRESS 3947 Ferrara Dr. Wheaton md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2/11/85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VA.					
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC.		ADDRESS 1804 T ST., N.W., WASH., D.C. 20009		25. DATE REC'D. BY REGISTRAR FEB 14 1985	
25b. REGISTRAR'S SIGNATURE [Signature]					

BP



REG. NO.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. HESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))

RECEIVED
NOV 10 1964
FBI

NOV 10 1964
FBI



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARGERET E. SMITH			2a. DATE OF DEATH MONTH DAY YEAR 02/25/85			2b. HOUR 6:50 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 15 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. 84		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Practical Nurse		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 311 Russell Ave. #1 20877	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Clayton Harris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Mae Trite							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-40-6667A		17. INFORMANT Wilson		ADDRESS 301 Russell Ave., Gaithersburg, Md. 20877			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable influenzal pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chronic paranoid psychosis, Tardive dyskinesia, ASD, Diabetes m.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from March 19, 1981 to Feb 25, 1985 , that (2) (we) lost saw the deceased alive on Feb 25, 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (3) (we) (did) (did not) view the body after death.										
22b. SIGNATURE James R. Moore Jr.			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-1-85		
22d. ADDRESS 207 Brookes Ave Gaithersburg Md										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/4/85		23c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Westminister Carroll Md.			
24. FUNERAL DIRECTOR Gartner Sandison F.H.			316 E. Diamond Ave. Gaithersburg, Md. 20877			25a. DATE REC'D. BY REGISTRAR MAR 05 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and consulted.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THERESE R Smolley			2a. DATE OF DEATH MONTH DAY YEAR Feb 26 1985			2b. HOUR 0204 A M				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 5 12 44		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9. CITIZEN OF WHAT COUNTRY? American		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
12. CITY OR TOWN OF DEATH Rockville		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		15. KIND OF BUSINESS OR INDUSTRY Public Defenders of		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Germantown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry H. Miller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara L. Coleman			16. STREET ADDRESS / ZIP CODE 17409 Onax Drive 20874				
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			17b. SOCIAL SECURITY NO. 186-34-3041			17. INFORMANT Donald M. Smolley			18. ADDRESS Item 13	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sclerosing Cholangitis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Years	
DUE TO, OR AS A CONSEQUENCE OF (b) Ulcerative Colitis									20 Years	
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Liver Failure; Biliary Sepsis										
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (the hospital) attended the deceased from 19 83 19 83 to 2/25 19 85 , that (I) (we) last saw the deceased alive on 2/25 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Alan N. Schulman, M.D.									22c. DATE SIGNED 2/26/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN N. SCHULMAN, M.D.									22e. ADDRESS ROCKVILLE, MD. 20850 9715 MEDICAL CENTER DRIVE - suite 404	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/28/88		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Beallsville, Md.		
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.						25a. DATE REC'D. BY REGISTRAR MAR 01 1985				
25b. REGISTRAR'S SIGNATURE [Signature]										

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Stephanie nmnm Sophar			2a. DATE OF DEATH MONTH DAY YEAR Feb. 28 1985			2b. HOUR 1:50p			
3 SEX Female		4 RACE White		5. DATE OF BIRTH Oct. 31 1898		6. AGE (IN YEARS LAST BIRTHDAY) 93		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR AND NO. OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Marcus			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Babette Simon			13e. STREET ADDRESS / ZIP CODE 1501 Glade Drive 20906			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 263-41-3599		17. INFORMANT Gerald J. Sophar		ADDRESS 3518 Fitzhugh Lane Silver Spring, Md. 20906			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA - Ruptured Blood Vessel DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12 10 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 121 10 83 248 25					
22a. I certify that (I) (this hospital) attended the deceased from 2/20 19 85 , to 2/28 19 85 , that (I) (we) last saw the deceased alive on 2/20 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Allan B. Cohan				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allan B. Cohan MD				22e. ADDRESS 13975 Conn. Ave. Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/1/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY TOWN COUNTY STATE Suitland, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 4 1985		25b. REGISTRAR'S SIGNATURE Richard R. Rouse			

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1951:00

Stephanie Ann

93

Oct. 21 1951

White

Female

Montgomery County

x

U.S.A.

Germany

None

Hannawille

Shocks Grove Mining House

City

1501 Glade Drive 20906

x

Montgomery Silver Spring

Maryland

Simon

Roberto

Patricia

Lucas

3718 Pittsburgh Lane

Gerald J. Nohr

253-41-3599

No

1501 Glade Drive, No. 20906

x

SAVES

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Scotland, Maryland

Coast Hill

2/1/52

Operation

Tyson Wheeler Funeral Home, Inc.

11711 Rockville Pike, Rockville, Maryland

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELSIE - SOUTHARD		2a. DATE OF DEATH MONTH DAY YEAR 2/11/85		2b. HOUR 850 P.M.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR AUG. 17, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH WHEATON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RANDOLPH HILLS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE-WIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID - DRYDEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA - BOUNDS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 221-24-5921		17. INFORMANT ADDRESS ELIZABETH LAYTON (DAUGHTER) SAME AS ITEM 13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) ventricular arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) acute Bronchitis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-27 , 19 84 , to 2-11 , 19 85 , that (I) (we) last saw the deceased alive on 11-27 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael A. Doback		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Feb 12 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Doback MD		22e. ADDRESS 13975 Conn. Ave Silver Spring MD 20906			
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 12 FEB 85		23c. NAME OF CEMETERY OR CREMATORY LEE CREMATORY	
23d. LOCATION WASHINGTON, D.C.		23e. COUNTY STATE			
24. FUNERAL DIRECTOR J. WILLIAM LEE'S SONS COMPANY NAME ADDRESS 300 4th ST. NE WASHINGTON, D.C. 20002				25a. DATE REC'D. BY REGISTRAR FEB 20 1985	
				25b. REGISTRAR'S SIGNATURE John Davidson-Ripley	

BP

SECRET

1. The purpose of this document is to provide information on the status of the project.

2. The project is currently in the planning stage.

3. The project is expected to be completed by the end of the year.

4. The project is being funded by the government.

5. The project is being managed by the project manager.

6. The project is being monitored by the project manager.

7. The project is being reported to the project manager.

8. The project is being reviewed by the project manager.

9. The project is being approved by the project manager.

10. The project is being implemented by the project manager.

11. The project is being evaluated by the project manager.

12. The project is being closed by the project manager.

13. The project is being archived by the project manager.

14. The project is being destroyed by the project manager.

15. The project is being transferred by the project manager.

16. The project is being re-evaluated by the project manager.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 1 4

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anthony James Sperduto			2a. DATE OF DEATH MONTH DAY YEAR February 6, 1985		2b. HOUR a.m. M. 5:00		
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 22, 1923		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 61	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 524 Calvin Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Musician		12b. KIND OF BUSINESS OR INDUSTRY Entertainment	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Peter Anthony Sperduto		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Augisano		13e. STREET ADDRESS / ZIP CODE 524 Calvin Lane 20851			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 088-14-6867		17. INFORMANT ADDRESS Nancy J. Fowler #1 Longworth Court Gaithersburg, Maryland 20879			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Hypertensive Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 years						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/12/1978 to 2/6/1985 , that (I) (we) last saw the deceased alive on 2/1/1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did not) view the body after death.							
22b. SIGNATURE Robert A. Macon				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED February 5, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Macon, M.D.				22e. ADDRESS 809 Viers Mill Road, Rockville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE February 9, 1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Montg. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. 300 W. Montgomery Ave., Rockville, Md. 20850				25. DATE REC'D. BY REGISTRAR FEB 8 1985		25b. REGISTRAR'S SIGNATURE Jane Davidson-Randall	

BP

March 11, 1941
Hague Consular District, 10-2-41

20% CBI



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD SOMERS SPERING					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 16, 1985			2b. HOUR 4:35 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 14, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH CHEVY CHASE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4601 N. PARK AVE.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LAWYER			12b. KIND OF BUSINESS OR INDUSTRY LAW		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL A. SPERING					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA BARRALCOUGH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 078-24-1588		17. INFORMANT ADDRESS ANNE SPERING, WIFE, SAME AS ITEM #13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEVERAL YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from JUNE 1984 to FEB 16 1985 , that (I) (we) lost saw the deceased alive on FEB 8 85 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE <i>Oscar Mann</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/16/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSCAR MANN, M.D.					22e. ADDRESS 3301 NEW MEXICO AVE., N.W., WASH., D.C. 20016					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 2/17/85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VA.			
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC.					25a. DATE REC'D. BY REGISTRAR FEB 20 1985					
1804 T ST., N.W., WASHINGTON, D.C. 20009					25b. REGISTRAR'S SIGNATURE <i>Gelia Davidson-Randall</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA MASON SPEROW			2a. DATE OF DEATH MONTH DAY YEAR 2 17 85		2b. HOUR P 2:15 P
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR July 21, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 94 years	7. IF UNDER 1 YEAR MONTHS DAYS YRS
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	9. CITIZEN OF WHAT COUNTRY? U.S.A.	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
12. CITY OR TOWN OF DEATH Rockville	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		15. KIND OF BUSINESS OR INDUSTRY at home..
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE West Virginia		13b. COUNTY Berkeley	13c. CITY OR TOWN Martinsburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George A. Mason		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Felker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 232-80-3877		17. INFORMANT Rev. Richard Reichard	
				ADDRESS 9701 Veirs Dr. Rockville, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**5 days**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

arteriosclerotic heart disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☒YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **May 2, 19 67** to **Feb 17 19 85**, that (I) (we) lost
saw the deceased alive on **Feb 15 19 85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

HAROLD F. McCANN**3355-16th St. N.W. WASH. D.C.**

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial

23b. DATE

Feb. 21, 1985

23c. NAME OF CEMETERY OR CREMATORY

Presbyterian Church Cem. Spring Mills, West Virginia

23d. LOCATION

20070

24. FUNERAL DIRECTOR

NAME

ADDRESS

The Hysong Co. 1300 N St. N.W. Washington, D.C.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

FEB 26 1985**J. H. Davidson**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or buried under any injury, or other traumatic event, the medicolegal case must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST ELLIOTT WALKER SPICER				2b. HOUR 9:05 A M			
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 29 94		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BELPRE HEALTH CARE CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY PAIST Brewery	
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES ALBERT SPICER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES HUMME		16. STREET ADDRESS / ZIP CODE 833 RICHMOND AVE. 20910			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 579-14-4843		17. INFORMANT ADDRESS MRS. ROBERT S. COOK			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH — YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a COLLAGENOUS COLITIS, RENAL INSUFFICIENCY							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTED BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —		22. I certify that (I) (this hospital) attended the deceased from JAN 19 84 to FEB 3 19 84 , that (I) (we) last saw the deceased alive on FEB 1 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.	
22a. SIGNATURE Arnold G. Levy MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/3/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARNOLD G. LEVY, M.D.		22e. ADDRESS 1106 SPRING ST. SILVER SPRING, MD. 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-5-85		23c. NAME OF CEMETERY OR CREMATORY WALKERS CHURCH		23d. LOCATION CITY OR TOWN COUNTY STATE MADISON MILLS, VA.	
24. FUNERAL DIRECTOR Donald Lee Neyles #104 MD ORANGE, VA				25a. DATE REC'D. BY REGISTRAR FEB 13 1985		25b. REGISTRAR'S SIGNATURE Gina Davidson-Randall	

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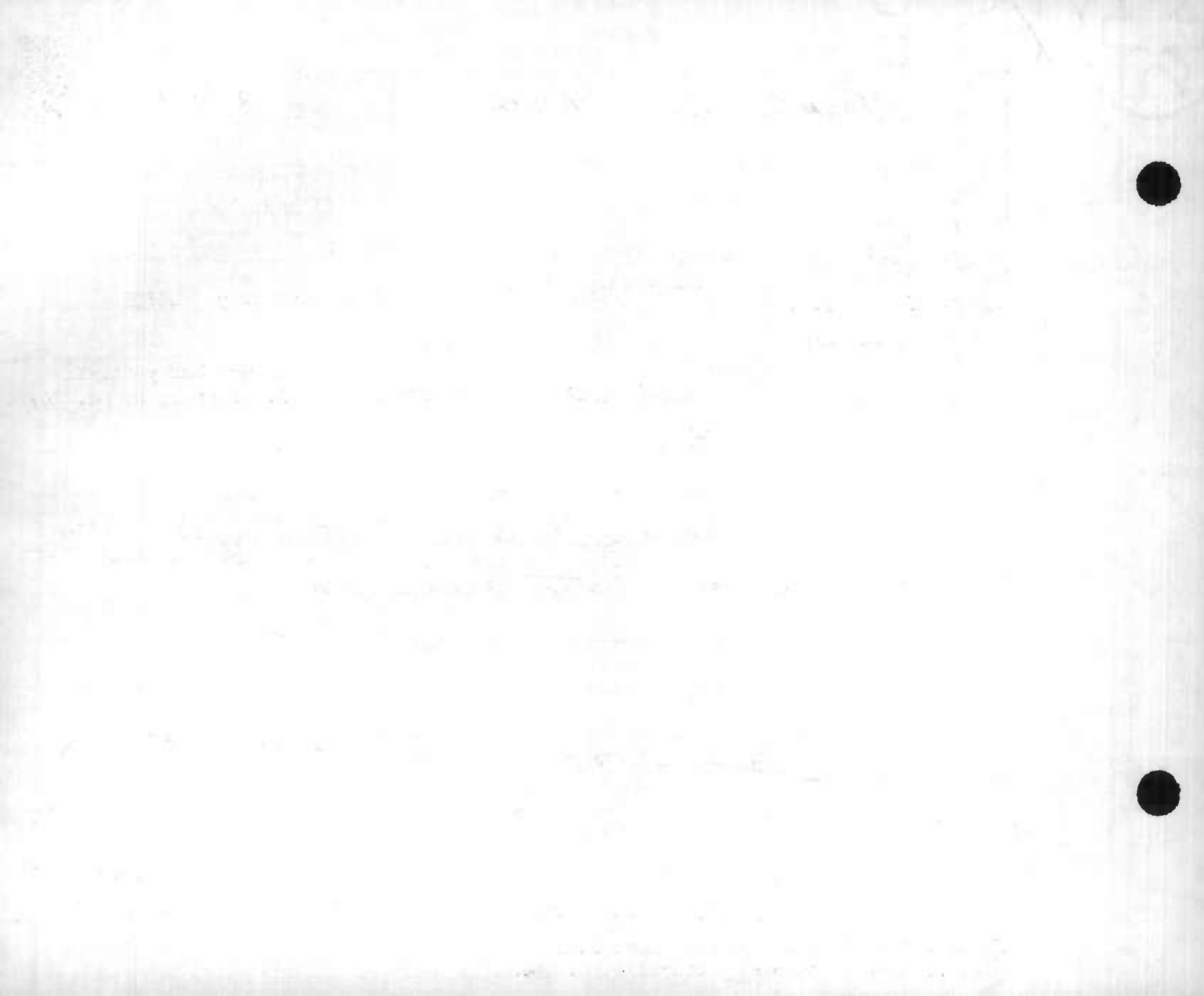
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FANNIE C. SPICKNALL			2a. DATE OF DEATH MONTH DAY YEAR 2/16/85		2b. HOUR 12 ³⁰ PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4-15-87	6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heritage Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY P.G.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 4115 Woodberry 20782	
14. FATHER'S NAME FIRST MIDDLE LAST James W. Northam			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia A. Evans			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-44-4326		17. INFORMANT 4115 Woodberry Street Florence Spicknall University Park, Md. 20782		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (b) General Debility DUE TO, OR AS A CONSEQUENCE OF: (c) Advanced Chronic Indigestion 20 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION Chronic Lymphatic Leukemia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 57 to 2-16-19 85, that (I) (we) lost saw the deceased alive on 2-15-19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Richard L. Whelton MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-16-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD L. WHELTON				22e. ADDRESS 7100 Baltimore Ave College Park P.G. Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/19/85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY Brentwood P.G. Maryland
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home P.A. 4739 Baltimore Avenue Hyattsville, Md. 20782				25. DATE REC'D. BY REGISTRAR FEB 21 1985		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Anne Spratt					2a. DATE OF DEATH MONTH DAY YEAR February 26, 1985			2b. HOUR 10²⁵ AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 30 1888		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spg.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper(Ret)		12b. KIND OF BUSINESS OR INDUSTRY Real Estate		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2700 Barker St., 20795		
14. FATHER'S NAME FIRST MIDDLE LAST James Peery Spratt					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lenora Godfrey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-07-1820		17. INFORMANT ADDRESS Virginia Dorothy S. Baumgardner, Box 172, Waterford,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) influenza DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Somnolence, Arteriosclerotic Vascular disease										
19a. DATE OF OPERATION 6/18/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1972 , 19____, to 2/26/85 , 19____, that (I) (we) lost saw the deceased alive on 1/8/85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jeremy V. Cooke					DEGREE MD		22c. DATE SIGNED 2/26/85		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Cook					22e. ADDRESS 10400 Conn. Ave. - Kensington, Md. 20895					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/28/1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016					25a. DATE RECD. BY REGISTRAR MAR 01 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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578-07-1800	Dorothy S. Baumgardner, Box 175, Waterford, Virginia	James Peery	Grant Lenora	Godfrey	2700 Parker St., 20725	Montgomery Silver Spring	2700 Parker St., 20725	Bookkeeper (et) Real Estate	Virginia	U.S.A.	xx	Montgomery	June 30 1888	22
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05820

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lester Franklin Stambaugh				2a. DATE KNOWN OF DEATH ESTIMATED Feb. 19 1988				2b. HOUR 8:00a	
3. SEX M	4. RACE W	5. DATE OF BIRTH (LAST BIRTHDAY) Sept 21 1907	6. AGE (IN YEARS) 77 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD Feb. 18 1988		7d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Pittsford		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10920 Conn Ave				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Self-employ	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Montgomery		13b. COUNTY Montgomery	13c. INSIDE CITY LIMITS? YES NO <input type="checkbox"/>	13d. STREET ADDRESS 10920 Conn Ave					
14. FATHER'S NAME FIRST MIDDLE LAST John Zell Stambaugh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Moyer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-07-5429		17. INFORMANT 57 Sherwood Drive Norma Young, Walkersville, MD. 21793					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): None									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE John P. Rogers		TITLE (SPECIFY) Dep					DATE SIGNED Feb 19 1988		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/22/85		23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick MD			
24. FUNERAL DIRECTOR NAME ADDRESS G. Douglas Stauffer, Walkersville, MD. 21793				25a. DATE REC'D. BY REGISTRAR FEB 25 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

RECEIVED
MEDICAL DEPARTMENT
U.S. ARMY
HOSPITAL
FORT MONMOUTH, N.J.

RECEIVED
MEDICAL DEPARTMENT
U.S. ARMY
HOSPITAL
FORT MONMOUTH, N.J.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Mildred C. Stapf			February 1, 1985			3:58 P		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
female	White	08 02 00		84 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.			Montgomery County Md.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Olney	Montgomery General Hospital			Homemaker		at home...		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland			Baltimore	Baltimore			116 W. University Parkway, Balt. Md.	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
George Backer			Clara Kaufman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no			213-74-3393		Mr. Jackson Bauer 500 Lymington Ct. Severna Pk Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>REFRIGERATORY PROGRESSIVE RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) that hospital attended the deceased from <u>1/10/85</u> , 19 <u>85</u> , to <u>FEB 1</u> , 19 <u>85</u> , that (1) <u>two</u> lost saw the deceased alive on <u>31 Jan</u> , 19 <u>85</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>Thomas E. Dudley, M.D.</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
<u>Thomas E. Dudley, M.D.</u>			<u>11904 GEORGETOWN AVENUE OLNEY, MARYLAND 20832</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			Feb. 5, 1985	Lorraine Park Cemetery Mausoleum		Baltimore, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>The Hysong Co. Inc. 1300 N St. N.W. Wash. D.C.</u>				FEB 8 1985		<u>[Signature]</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 2 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Annie Lee Steed			2a. DATE OF DEATH MONTH DAY YEAR February 15, 1985			2b. HOUR 1:20A _M					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 20, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (IF DIFFERENT FROM WORKING LIFE) Accounting Clerk		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7816 Maple Ridge Road / 20814	
14. FATHER'S NAME FIRST MIDDLE LAST Newbern Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Granstaff								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - 216-44-9280		17. INFORMANT Maura R. Steed, Daughter-in-law ADDRESS 6 Foxboro, St. Louis, Missouri 63124						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Control insufficiency</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours			
								24 hours			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>April</u> 19 <u>83</u> to <u>3/15</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>2/14</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										22c. DATE SIGNED Feb. 15, 1985	
22b. SIGNATURE <u>Lewis N. Cahill</u>			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis N. Cahill, M.D.			22e. ADDRESS 5411 Cedar Lane#202a Bethesda, Maryland 20814								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE February 19, 1985		23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Palmetto Georgia				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814			25a. DATE REC'D. BY REGISTRAR FEB 21 1985			25b. REGISTRAR'S SIGNATURE <u>Davidson-Rendell</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18, state any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OF ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST JOSEPH THOMAS STEFFES				20. Feb. 18 1985			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR Sept 26 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES ENGINEER		12b. KIND OF INDUSTRY HAMILTON MANUFACTURING	
13a. STATE MARYLAND				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST SIMON STEFFES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA KUNZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 392-10-2655		17. INFORMANT ADDRESS JOHN THOMAS STEFFES SAME AS 13 SON			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE MYOCARDIAL INFARCTIONS DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIVE HEART FAILURE; METASTATIC LUNG CANCER Approximate interval between onset and death: INSTANT YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONDITIVE HEART FAILURE; METASTATIC LUNG CANCER							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from February 19, 84 to 2/18 1985 , that (2) we last saw the deceased alive above (1) on 2/14 1985 , and that (3) our opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Martin C. Sharbell M.D.				DEGREE M.D.		22c. DATE SIGNED 2/19/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARBELL M.D.				22e. ADDRESS 3720 FARLEIGH AVE KENSINGTON, MD - 20895			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/23/85		23c. NAME OF CEMETERY OR CREMATORY FOREST VIEW		23d. LOCATION CITY OR TOWN COUNTY STATE TWO RIVERS MANITOWOC WISCONSIN	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR FEB 25 1985			
24. ADDRESS 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901				25b. REGISTRAR'S SIGNATURE Lila Davidson-Randall			

BP _____

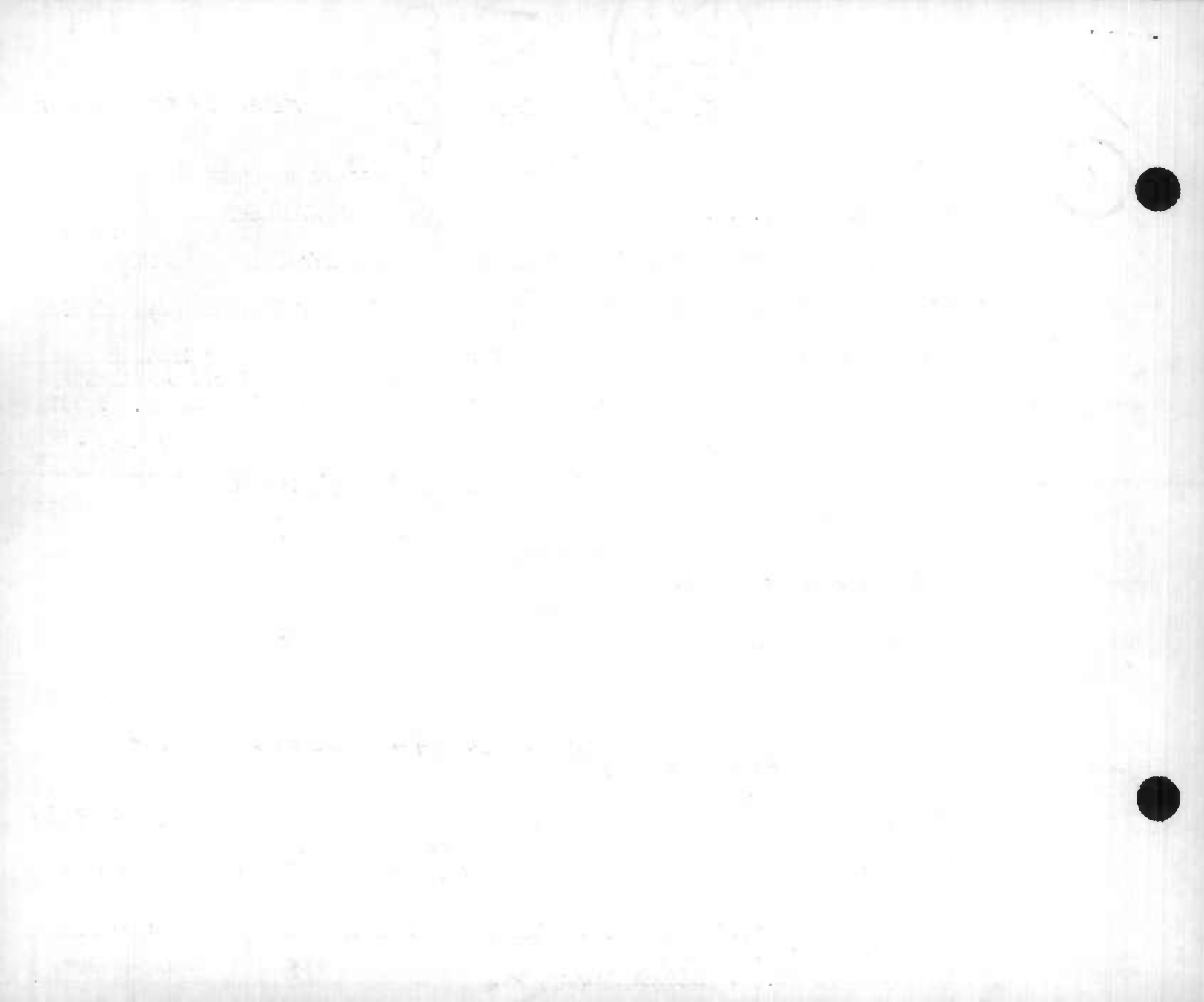


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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ANNA T. STEINECKE		FEB. 24, 1985		4:15 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
FEMALE	CAUCASIAN	OCTOBER 22, 1901	83	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
NEW YORK CITY	U.S.A.		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK	HERITAGE HEALTH CARE CENTER	SECRETARY	FAMILY OWNED		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MARYLAND	MONTGOMERY	SILVER SPRING	YES <input type="checkbox"/> NO <input type="checkbox"/>	8505 SPRINGVALE ROAD 20910	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. ADDRESS			
JOHN W. TIEDEMANN	EMMA KRUMHOLZ	16012 JERALD ROAD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
NO	100-24-2344	CHARLES STEINECKE, III	LAUREL, MD. 20707		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Influenza					
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulm. disease					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
MALNUTRITION					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from APR. 29, 1977 to 24 FEB. 1985, that (I) (we) lost saw the deceased alive on FEB 10, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
HUBERT J. ALPERT	MD				25 FEB 85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
HUBERT J. ALPERT	8620 FENTON ST. SILVER SPRING, MD 20910				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	CITY OR TOWN	COUNTY STATE
Cremation	Feb. 28, 1985	Metropolitan Crematory	Alexandria		Virginia
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR				
NAME	25b. REGISTRAR'S SIGNATURE				
Francis J. Collins	MAR 1 1985 Julia Davidson-Pendell				
500 University Blvd., W. Silver Spring, Md.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

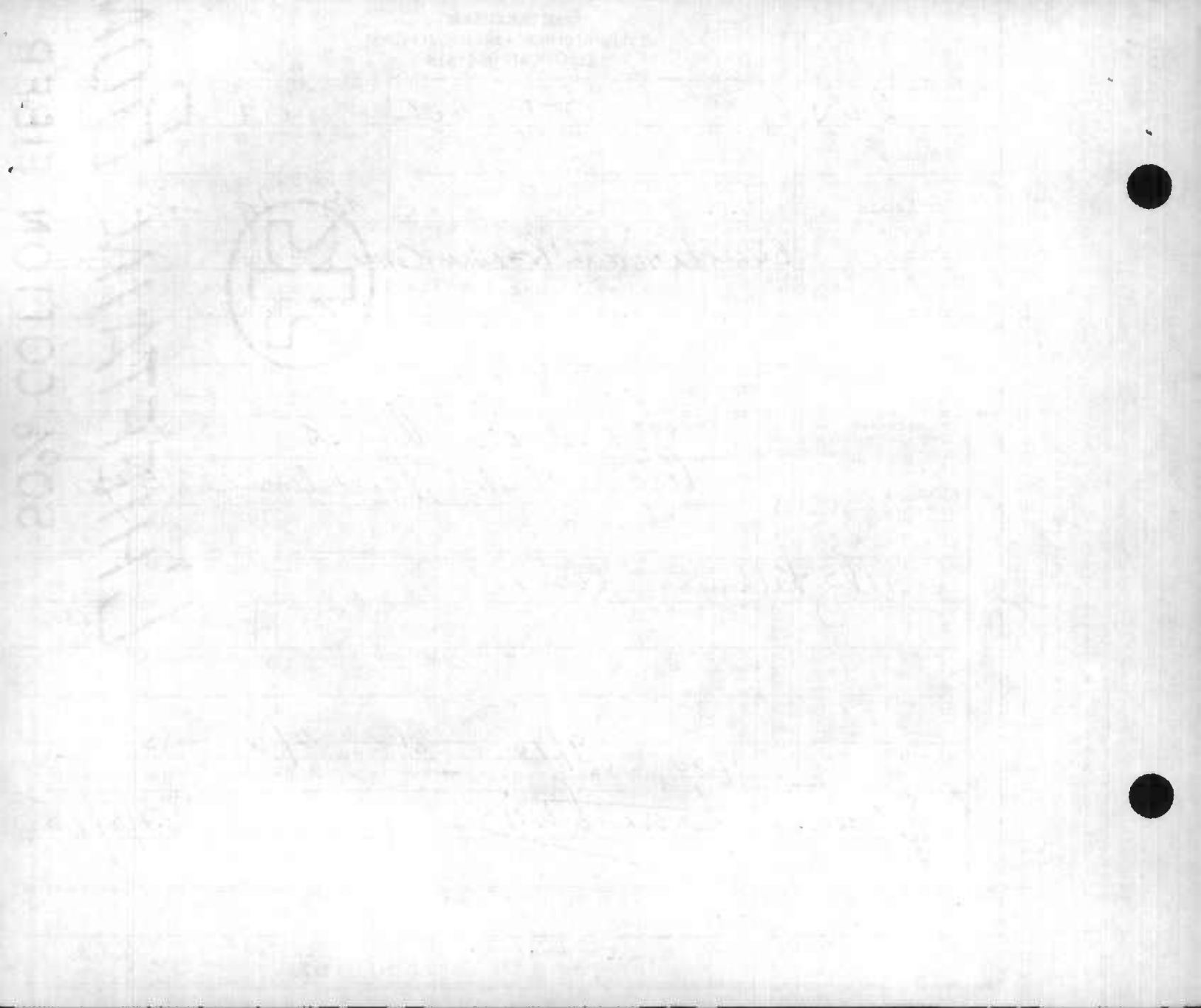
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruth STEINER			2a. DATE OF DEATH MONTH DAY YEAR 02 06 '85			2b. HOUR 2 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 20 02		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Nursing/Retirement Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker		12b. KIND OF BUSINESS OR INDUSTRY Real Estate			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 901 Holborn St. 20902			
14. FATHER'S NAME FIRST MIDDLE LAST William Tomai				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Weir							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.		16b. SOCIAL SECURITY NO. 575-09-2448		17. INFORMANT Ms. Geneva Coleman				ADDRESS - Same as #13			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Heart disease										5 years	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Alzheimers disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/16 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) 2/6 85							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2/6 85							
22a. I certify that (I) (this hospital) attended the deceased from 9/16 81 to 2/6 85 , that (I) (we) last saw the deceased alive on 1/30 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.											
22b. SIGNATURE Gene Davidson				22c. DATE SIGNED 2/6/85							
22d. PHYSICIAN'S EXEMPTION (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/6/85		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.			
24. FUNERAL DIRECTOR NAME ANATOMY BOARD				25a. DATE REC'D. BY REGISTRAR FEB 7 1985				25b. REGISTRAR'S SIGNATURE Gene Davidson-Randall			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bertha A Stewart			2a. DATE OF DEATH MONTH DAY YEAR 2-17-85		2b. HOUR 9:30 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11-01-98		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ill.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse	12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 14115 Chelmsford Road 20850	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer E. Coale		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Phar			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-42-8149		17. INFORMANT ADDRESS Joseph E. Fimiani same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Dehydration DUE TO, OR AS A CONSEQUENCE OF (c) CNF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1985 1985 1985
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASCVD, Recurrent CVA, COPD, OJD					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that Dr. G. B. Patrick attended the deceased from 12/1/81 , 19____, to 2/17/85 , 19____, that (11) (10) he saw the deceased alive on 2/16/85 , 19____, and that in my (my) own opinion death occurred on the date and hour and from the causes stated above. (11) (10) he did not view the body after death.					
22b. SIGNATURE G B Patrick MD		DEGREE		22c. DATE SIGNED 2-17-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G B Patrick MD		22e. ADDRESS 9221 Lakesville Rd Silver Spring, Md 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 2/20/85	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arl. VA	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home		ADDRESS 4308 Suitland Road Suitland MD		25a. DATE REC'D. BY REGISTRAR FEB 22 1985	
		25b. REGISTRAR'S SIGNATURE G. E. Fimiani			

BP. _____

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Harriette Genevieve Stokes			2a DATE OF DEATH MONTH DAY YEAR February 19, 1985		2b HOUR 7:03A.M.						
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Sept. 30, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 9200 Darnestown Road 20850			
14 FATHER'S NAME FIRST MIDDLE LAST John E. O'Neil				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth D. Corkery							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 12 0741		17 INFORMANT daughter Harriette Veirs 9200 Darnestown Road Rockville, Maryland 20850							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Brain Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION N/A		19b CONDITION FOR WHICH OPERATION WAS PERFORMED N/A				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE N/A							
22a I certify that (I) (this hospital) attended the deceased from <u>11-3</u> , 19 <u>72</u> , to <u>2-19</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>George T. Economos, M.D.</u> DEGREE								22c DATE SIGNED 2/19/85			
22d PHYSICIAN'S NAME (TYPE OR PRINT) George T. Economos, M.D.				22e ADDRESS 2141 K Street N.W. Washington, D.C. 20037							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Feb. 23, 1985		23c NAME OF CEMETERY OR CREMATORY St. Mary's Catholic Church				23d LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland				25 DIRECTOR'S REGISTRAR FEB 23 1985 25b REGISTRAR'S SIGNATURE <u>John Davidson</u>							

20% COTTON FIBER

DAVID KIM JDM



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 2 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLYDE S. STOTLER			2a. DATE OF DEATH MONTH DAY YEAR February 5, 1985			2b. HOUR 2:40 P.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 5, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Illinois			13b. COUNTY Woodford		13c. CITY OR TOWN El Paso		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Walter Stotler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hulda Stephens			16. STREET ADDRESS / ZIP CODE Rural Route 1 99999			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17. INFORMANT 10225 Kensington Parkway Leila Snyder Kensington, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CLINICAL ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 Hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from FEB 1985 to FEB 1985, that (I) (we) last saw the deceased alive on FEB 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas E. Dooley, MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5 FEB 1985			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Dooley, MD			22e. ADDRESS 17904 GEORGIA AVENUE OLNEY, MARYLAND 20832						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 8, 1985		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE El Paso, Illinois		
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND					25a. DATE RECEIVED BY REGISTRAR FEB 8 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Rendell		

21

22

23

2028 COLLECTION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 2 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lynn Clement Strait			2a. DATE OF DEATH MONTH DAY YEAR Feb. 16, 1985			2b. HOUR 8:51 pm			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 3, 1954		6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) management analyst		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Michigan Calhoun Battle Creek					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9 Edgemont St 49017		
14. FATHER'S NAME FIRST MIDDLE LAST Lloyd R. Strait					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leone Davis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1972-76		17. INFORMANT ADDRESS Kathleen Strait same as above					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) INTRACEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) Nontraumatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes ~ 24 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION 0			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —				
22a. I certify that (I) (this hospital) attended the deceased from 16 Feb 1985 to 16 Feb 85 19____, that (I) (we) lost saw the deceased alive on 16 Feb 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ronald H. Uscinski					DEGREE MD			22c. DATE SIGNED 17 Feb 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD H. Uscinski					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE February 22, 1985		23c. NAME OF CEMETERY OR CREMATORY Fort Custer Nat'l		23d. LOCATION CITY OR TOWN COUNTY STATE Battle Creek, Michigan		
24. FUNERAL DIRECTOR NAME ADDRESS Donaldson Funeral Home, Laurel, Maryland					25a. DATE REC'D. BY REGISTRAR FEB 26 1985		25b. REGISTRAR'S SIGNATURE John Davidson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30% COTTON LINT

EXTRA



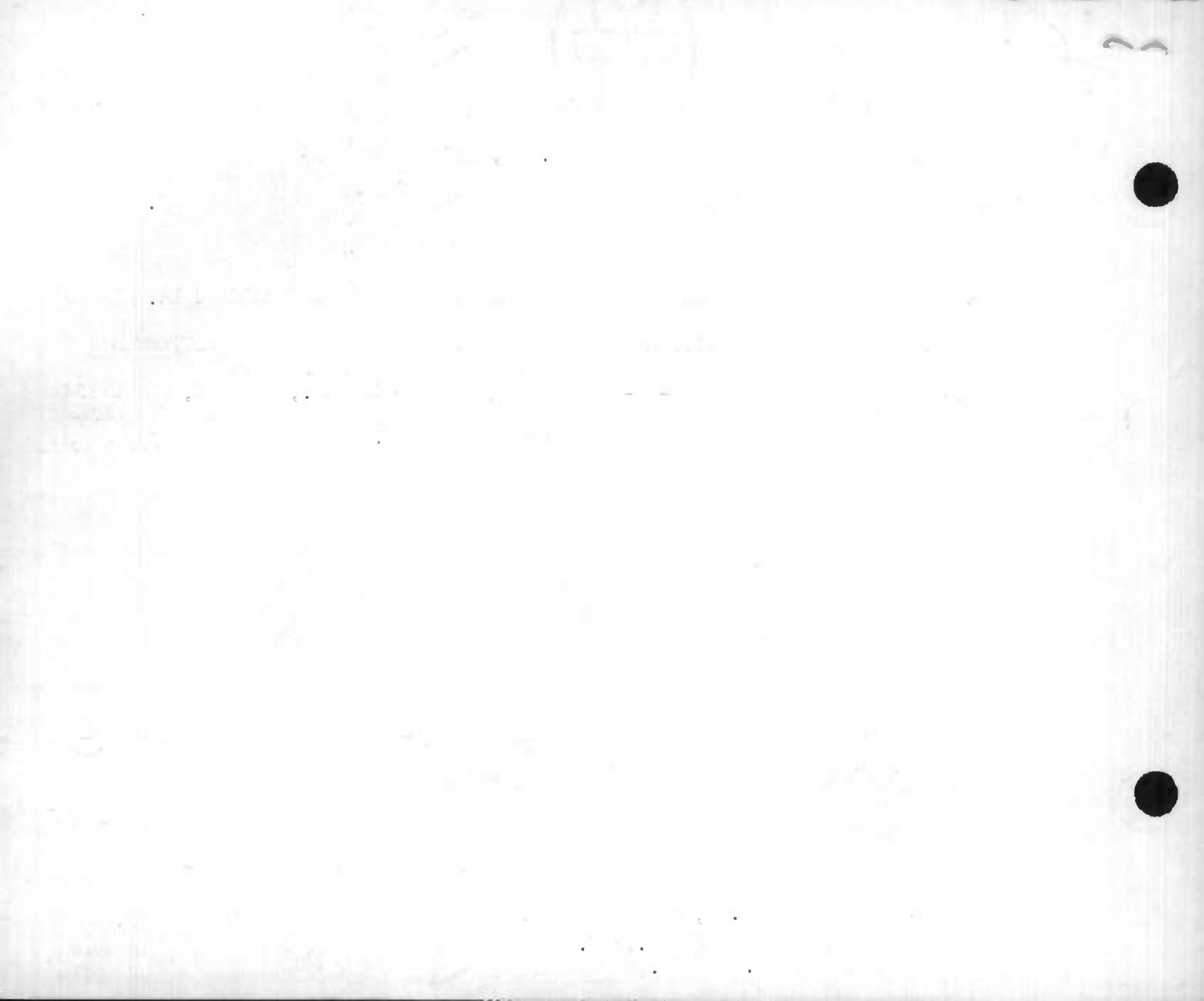
NO. 1

10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian Stulman			2a. DATE OF DEATH MONTH DAY YEAR 2 16 85		2b. HOUR 5:37P.M.		
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR OCT. 27, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery CO. MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY WOOL	
13a. STATE MARYLAND				13b. COUNTY N		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID STULMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA BETTLEMAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 220-12-6178		17. INFORMANT CHARLES BLUMBERG 8604 TIMBER HILL LA., POTOMAC, MD 20854					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>shock, probably cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>2/15</u> , 19 <u>85</u> , to <u>2/16</u> , 19 <u>85</u> , that (1) (he) last saw the deceased alive on <u>2/16</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes, (did) (did not) view the body after death.							
22b. SIGNATURE <u>Mark Rosen</u>		22c. DATE SIGNED <u>2/16/85</u>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Rosen	
22e. ADDRESS Silver Spring, MD		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL					
23b. DATE FEB. 18, 1985		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR FEB 20 1985			
25b. REGISTRAR'S SIGNATURE <u>Jane Warden</u>							



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 3 0 5 8 3 1

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alejandrina Suarez			2a. DATE OF DEATH MONTH DAY YEAR February 3, 1985			2b. HOUR 8:30A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 1, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Spain		7b. CITIZEN OF WHAT COUNTRY? Spain		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3600 Cardiff Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3600 Cardiff Road 20815	
14. FATHER'S NAME FIRST MIDDLE LAST Jose Suarez		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Encarnacion Fernandez		17. INFORMANT Daughter 4222 McCain Court Encarnacion Garcia Kensington, Md 20895					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 62 1861							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 80 to January 19 85 , that (I) (we) last saw the deceased alive on January 7 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jorge H. Forcada M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Feb. 4, 1985			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jorge H. Forcada, M.D.				22e. ADDRESS 1106 Spring Street #2 Silver Spring, Md. 20895					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 5, 1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR FEB 7 1985		25b. REGISTRAR'S SIGNATURE Wardson-Randall			

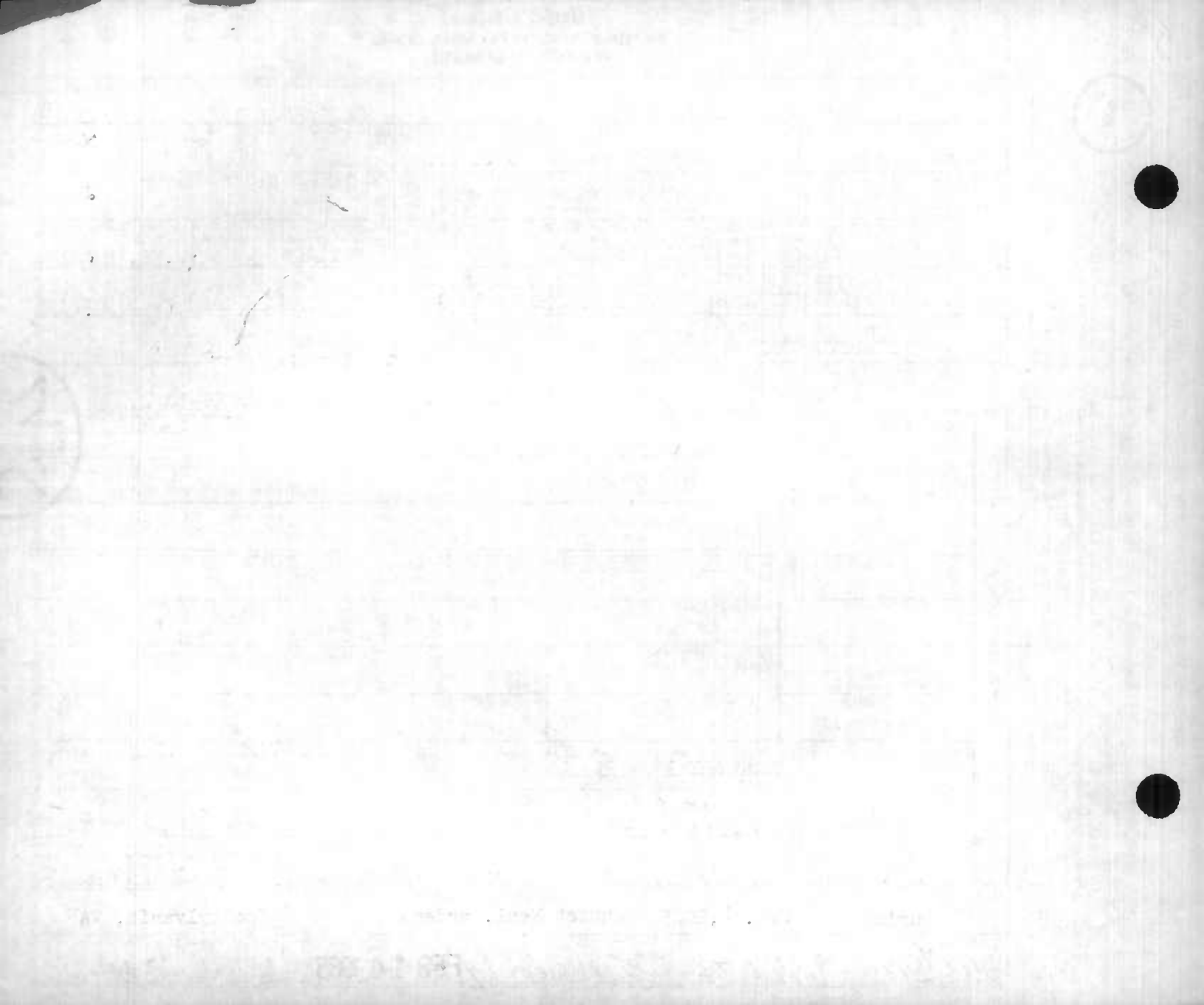


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) LAWRENCE LEE SUTLER					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 1 1985			2b. HOUR 5:30 a.m.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 29 1934		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U. S. MARINES	
13a. STATE VIRGINIA		13b. COUNTY SPOTSYLVANIA		13c. CITY OR TOWN FREDERICKSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4519 BRANDON LANE 9999 22401	
14. FATHER'S NAME FIRST MIDDLE LAST MEREDITH CARL SUTLER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE LOUISE RHODES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1952-1972		17. INFORMANT JACKLYN A. SUTLER		ADDRESS 4519 BRANDON LANE,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					FREDERICKSBURG, VA 22401		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 23 19 85 , to FEBRUARY 1 19 85 , that (I) (we) last saw the deceased alive on FEBRUARY 1 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James B. Hermiller</i> MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1 Feb 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. B. HERMILLER, LT, MC, USNR					22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 4, 1985		23c. NAME OF CEMETERY OR CREMATORY Sunset Meml. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Spotsylvania, VA			
24. FUNERAL DIRECTOR NAME <i>Wilson Smith</i>					25a. DATE REC'D. BY REGISTRAR FEB 14 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		



changed to sign in the Registry
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 3 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agnes T. Talbott			2a. DATE OF DEATH MONTH DAY YEAR 2 25 85		2b. HOUR 0917am M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 06 03 1900		
6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Takoma Park, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 19611 Crystal Rock Drive 20874		
13c. CITY OR TOWN Germantown		13d. STREET ADDRESS / ZIP CODE 19611 Crystal Rock Drive 20874		14. FATHER'S NAME FIRST MIDDLE LAST Joseph Phelps		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyn Baeschlin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217 12 5612		
17. INFORMANT Rose Suit (Daughter)		ADDRESS Same as 13e		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive lung disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d)		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (it/this hospital) attended the deceased from <u>2/25/85</u> to <u>2/25/85</u> , that (I) (we) last saw the deceased alive on <u>2/25/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.		22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED 2/25/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. BRAHAM DASELA		22e. ADDRESS 4404 Queensbury Rd. Riverdale Md.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		
23b. DATE 2/28/85		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR (NAME ADDRESS) Francis Gersch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR FEB 28 1985		25b. REGISTRAR'S SIGNATURE P. A. Davidson		

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as in 18 with any injury, or other traumatic event, the medical record must be available at time of death.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Christina (WMA) Tarasuk			2a. DATE OF DEATH MONTH DAY YEAR 1 - 31 - 85			2b. HOUR 7 40 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 15, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adv. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE W. Virginia		13c. CITY OR TOWN Grant Town		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Box 194 26574		14. FATHER'S NAME FIRST MIDDLE LAST Not available		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not available		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 232 96 5951		17. INFORMANT Paul Tarasuk		ADDRESS 17629 Wheat Fall Drive Derwood, Maryland			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive Heart Failure		2 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Asthmatic Bronchitis; Pneumonia			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ROW 18, PART I OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the undersigned) attended the deceased from 1/30/85 to 1/31/85, that (I) (last saw the deceased alive on 1/30/85 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If I did not see the body after death.			
22b. SIGNATURE Carl I. Schoenberger		22c. ADDRESS 4701 Randolph Rd Rockville	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 2, 1985		23c. NAME OF CEMETERY OR CREMATORY Maple Grove		23d. LOCATION CITY OR TOWN COUNTY STATE Fairmont West Virginia	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.



RECEIVED
JAN 10 1951

TO THE DIRECTOR

FROM THE DIRECTOR

RE: [illegible]

[illegible]

Very truly yours,
[illegible signature]

RECEIVED
JAN 10 1951

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 3 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EMMA Elizabeth M LOR			2a. DATE OF DEATH MONTH DAY YEAR 2 25 85			2b. HOUR 3:58 A M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 12, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10518 DeNeane Road 20903	
14. FATHER'S NAME FIRST MIDDLE LAST Milton Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Mae Dutrow							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-16-6729		17. INFORMANT Daughter		ADDRESS 12606 Kemmerton Lane Melissa E. Grzembksi Bowie, Md. 20715			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Known 9 yrs. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia left upper lobe										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Feb 6 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from Feb 6 19 76 to Feb 15 19 85 , that (I) (did) saw the deceased alive on Feb 28 19 85 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.										
22b. SIGNATURE Aaron H. Traum			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED February 25 1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aaron H. Traum, M.D.			22e. ADDRESS 8915 Georgia Avenue Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 28, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Maryland			
24. FUNERAL DIRECTOR NAME Francis J. Collins			25a. DATE REC'D. BY REGISTRAR MAR 1 1985			25b. REGISTRAR'S SIGNATURE John Burdson				
500 University Blvd., W. Silver Spring, Md.										

55

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 3 6

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Irene M. Taylor			2a. DATE OF DEATH MONTH DAY YEAR February 26, 1985		2b. HOUR 1:30 a.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR JAN. 14, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 299 HURLEY AVE 20850	
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW PIERCE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELVIG SCHULLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 105-05-7333B		17. INFORMANT ADDRESS 10 CLEMSON CT. ROCKVILLE, MD. 20850	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/26 19 84 to 2/26 19 85 that (I) (we) last saw the deceased alive on 2/24 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Frauke Westphal	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED Feb/26/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Frauke Westphal, M.D.		22e. ADDRESS 809 Viers Mill Rd. Rockville, Maryland	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE FEB. 27, 1985	23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G. Co., Maryland
24. FUNERAL DIRECTOR NAME Chambers Funeral Home		25. DATE RECEIVED BY REGISTRAR FEB 28 1985	
ADDRESS Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE A. Davidson-Randall	

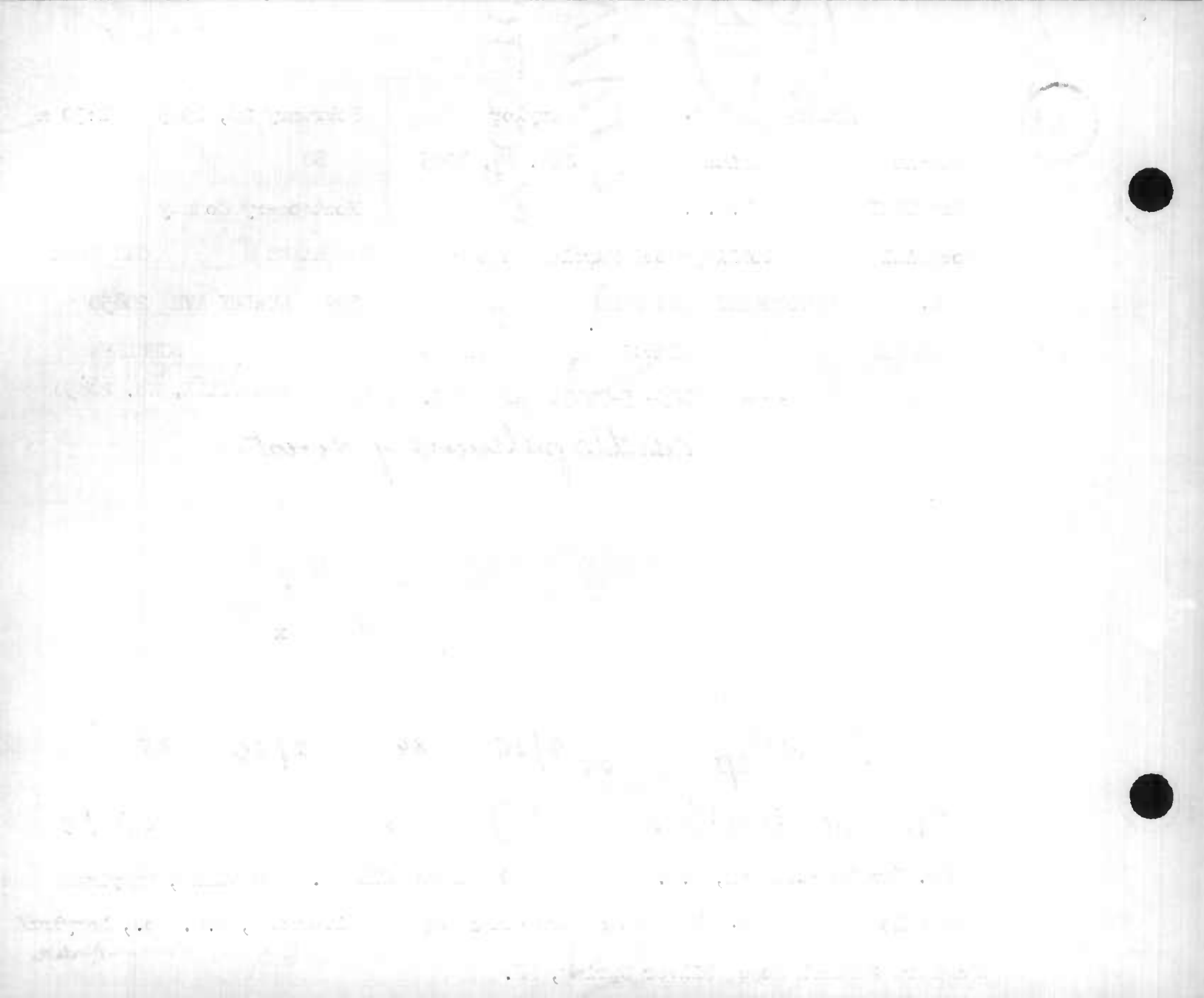
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 3 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Beatrice D. Tennant			2a. DATE OF DEATH MONTH DAY YEAR 2 6 85			2b. HOUR 3:18 A.M.				
3. SEX F		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 7, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER		12b. KIND OF BUSINESS OR INDUSTRY THOMAS SOMMERVILLE CO.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 7805 COLE AVENUE 20912			14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM G. SLAYTON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SHARA COLE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 224-10-5365		17. INFORMANT DAUGHTER MARIAN D. ADDABBO				ADDRESS 9209 WORTH AVENUE SILVER SPRING, MD. 20901	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis Generalized</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4 Feb 1985</u> to <u>6 Feb 1985</u> , that (we) (we) lost saw the deceased alive on <u>6 Feb 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Thomas P. Fogarty</u>			22c. DATE SIGNED <u>6 Feb 85</u>					22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS P. FOGARTY			22f. ADDRESS SILVER SPRING, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/8/85		23c. NAME OF CEMETERY OR CREMATORY HIGHLAND BURIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE DANVILLE, PITTSBURGH, VA.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS			25a. DATE REC'D. BY REGISTRAR FEB 11 1985			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Henderson</u>				
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										

MEDICAL CERTIFICATION

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

AND BURR.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANCES K. THEOHARIS			2a. DATE OF DEATH MONTH DAY YEAR Feb. 27, 1985		2b. HOUR 12:27am	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1927	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 12:27am	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STREET ADDRESS 816 Gist Ave. 20143			
13a. STATE MD	13b. COUNTY Mont.	13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Frank Paleologous		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Despina UNK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None		16b. SOCIAL SECURITY NO. 220 12 3017		17. INFORMANT ADDRESS Same as 13E Athanasios Theoharis (Husband)		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **INTRACEREBRAL / SUBARACHNOID HAEMORRHAGE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **INTRACRANIAL ANEURYSM**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:0 P.M. 2.26. 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2.26. 1985 , to 2.27. 1985 , that (I) (we) last saw the deceased alive on 2.27. 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE B. JOSHI M.D.				DEGREE MD		22c. DATE SIGNED 2.27.85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. JOSHI M.D.				22e. ADDRESS 344 UNIVERSITY BLVD. WES. #216 SILVER SPRING Md. 20901			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/1/85	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md.
24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 New Hamp.Ave.S.S.Md.		25a. DATE REC'D. BY REGISTRAR MAR 4 1985	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

THE UNIVERSITY OF CHICAGO
LIBRARY

A



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Raymond E. Thomas			2a. DATE KNOWN OF DEATH MONTH DAY YEAR XX 2-2 19 85			2b. HOUR M 8:05 a.m.		
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR May 13, 1922	6 AGE (IN YEARS) LAST BIRTHDAY 62	IF UNDER 1 YR. MONTHS DAYS 62	IF UNDER 24 HRS. HOURS MIN. 62	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2-2 19 85		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10 CITY OR TOWN OF DEATH Sandy Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18567 Brooke Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Montg.	13c. CITY OR TOWN Sandy Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 18567 Brooke Rd.		20860
14. FATHER'S NAME FIRST MIDDLE LAST Raymond W. Thomas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeanette Walker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Dorothy Thomas (Sister) same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 2-3-85
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-8-85		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg. Md.		
24. FUNERAL DIRECTOR NAME George R. Snowden				ADDRESS 246 N. Washington St. Rockville, Md. 20850		25. REGISTRY OF DEATHS FEB 07 1985		

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



20% COTTON FIBER

DMC

WINTER

FEB 01 1952

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 4 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LeRoy Glen Thompson			2a. DATE OF DEATH MONTH DAY YEAR 2 11 85			2b. HOUR 7:03 A.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 7 03 00 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Solar Laser Tech.		12b. KIND OF BUSINESS OR INDUSTRY Solar Mfg.	
13a. STATE West Virginia				13b. COUNTY Greenbrier		13c. CITY OR TOWN White Sulphur Springs		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Glen Lindon Thompson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Parker				13e. STREET ADDRESS / ZIP CODE 38 Patterson St./24986	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII & Korea		17. INFORMANT ADDRESS Theda W. Thompson (wife) same as 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma of Lung

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

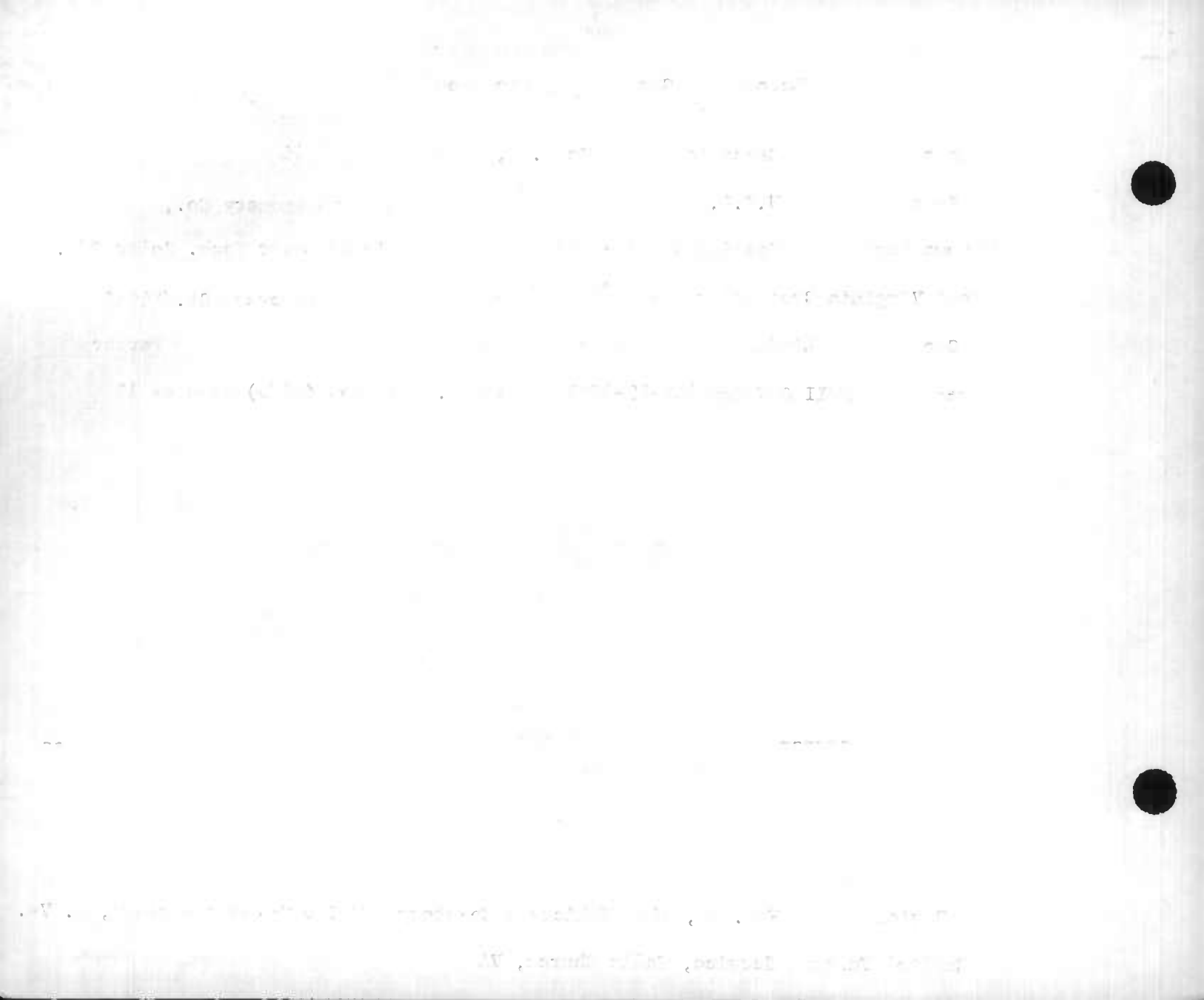
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**2 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/23 , 19 85 , to 2/11/85 , 19 85 , that (I) (we) first saw the deceased alive on 2/9 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. L. C. Bruce				DEGREE MD		22c. DATE SIGNED 2/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. L. C. Bruce				22e. ADDRESS 1100 Oakview Ave, Takoma Park			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 14, 1985		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE White Sulphur Springs, W. Va.	
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA				25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE W. W. W. W. W.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Martha P. Thornton			2a. DATE OF DEATH MONTH DAY YEAR February 13, 1985			2b. HOUR 6:32AM					
3. SEX Female		4. RACE Black		5. DATE OF BIRTH Feb. 28, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 94		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS 7826 Scotland Dr. 20850		
14. FATHER'S NAME FIRST MIDDLE LAST John Pumphrey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Powell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-18-9816		17. INFORMANT ADDRESS Thomas Thornton (Son) same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular failure</i> DUE TO, OR AS A CONSEQUENCE OF <i>Myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>2nd year</i> (b) <i>Chronic obstructive pulmonary disease</i> DUE TO, OR AS A CONSEQUENCE OF <i>2nd year</i> (c) <i>Chronic obstructive pulmonary disease</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Chronic obstructive pulmonary disease</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>2/12/85</i> to <i>2/13/85</i> , that (I) (we) last saw the deceased alive on <i>2/12/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE <i>Charles Ligon</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/13/85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Ligon, M.D.						22e. ADDRESS <i>1811 P + Phylip Dr., Olney, Md. 20850</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-18-85		23c. NAME OF CEMETERY OR CREMATORY Hopkins Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Highland, Howard, Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden						24b. ADDRESS 246 N. Wash. St. Rockville, Md. 20850		25a. DATE REC'D. BY REGISTRAR <i>2/13/85</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

BP



100%
COTTON
FIBER

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF THE DEATH IS SUSPECTED TO BE A BURIAL-TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Joyce Virginia Tippenhauer

3. SEX

4. RACE

female white

5. DATE OF BIRTH

9 12 12

6. AGE, YEARS

72 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS

2a. DATE KNOWN
OF
DEATH ESTI-
MATED

2 3 85

7b. HOUR
400 P M2c. DATE
PRONOUNCED
DEAD

2 3 85

P M

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Minnesota

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD

10. CITY OR TOWN OF DEATH

Rockville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

6420 Needle Leaf Drive

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

housewife

12b. KIND OF BUSINESS
OR INDUSTRY

home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Rockville

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

6420 Needle Leaf Drive 20852

14. FATHER'S NAME

James

MIDDLE

B.

LAST

Hoover

15. MOTHER'S MAIDEN NAME

Treat

MIDDLE

LAST

Whitney

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

477 36 0590

17. INFORMANT

ADDRESS

Nellie Tippenhauer same as 13e

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

asphyxiation

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

Hanging

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.ACTUAL
SIGNATURE

John Tauber

TITLE (SPECIFY)
M.D. Deputy

MEDICAL EXAMINER

DATE
SIGNED

2-3-85

EXAMINER'S NAME
(TYPE OR PRINT)

John Tauber

ADDRESS

8218 WISCONSIN AVE

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

2/6/85

23c. NAME OF CEMETERY OR CREMATORY

Richville Cemetery

23d. LOCATION
CITY OR TOWN

Ottertail, Minnesota

STATE

24. FUNERAL DIRECTOR

Tyson Wheeler Funeral Home, Inc.

1331 Rockville Pike, Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR

FEB 7 1985

25b. REGISTRAR'S SIGNATURE

John Tauber

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Film G600 item 7a
FOR 2/25/85 rja
1- STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 4 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Katherine A. Townsend</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>February 12, 1985</u>			2b. HOUR P M <u>3:00 P</u>			
3 SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Jan. 27, 1893</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>92</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE STATE AND COUNTY <u>New Jersey</u>		7b. CITIZEN OF WHAT COUNTRY? (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.			
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Collingswood Nursing Home</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Clerk</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Census Bureau</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u>			13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Rockville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Leary</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>880 College Parkway # 301 20850</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>577-32-9849</u>		17. INFORMANT ADDRESS <u>Gerald J. Townsend Son Same as 13</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>5 hr</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebrovascular accident</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> 19 <u>80</u> to <u>2/12</u> 19 <u>85</u> , that (I/we) lost saw the deceased alive on <u>2/12</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) see the body after death.									
22b. SIGNATURE <u>Myron L. Lenkin</u> M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED <u>2/12/85</u>			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MYRON L. LENKIN</u> M.D.		22e. ADDRESS <u>2309 SAOREFIELD RD WHEATON, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Feb. 15, 1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Arlington Virginia</u>			
24. FUNERAL DIRECTOR NAME <u>Francis J. Collins</u>				25a. DATE REC'D. BY REGISTRAR <u>FEB 19 1985</u>		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			
500 University Blvd., W. Silver Spring, Md.									

BP



CO-104 L-105

WATER

11/10/10

10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LYDIA TSCHERNEY		2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 22, 1985		2b. HOUR 0730A	
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR MAY 29, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia	7b. CITIZEN OF WHAT COUNTRY? Germany	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2806 Blaine Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE MD		13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alois -- Buchheibel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria -- Bender		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 219-54-9528		17. INFORMANT ADDRESS Lydia Kester, Same address as #13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): HYPERTENSION. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 1, 1977 to FEB. 22, 1985 , that (I) (we) lost saw the deceased alive on Feb 21, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jerry Allison Snow, MD		DEGREE		22c. DATE SIGNED 2-22-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JERRY ALLISON SNOW MD		22e. ADDRESS 4900 MARYLAND AVE, N.W., 20016			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/25/85		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016			

CORNER DR. ROGERS NOTIFIED BODY REMOVED

Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

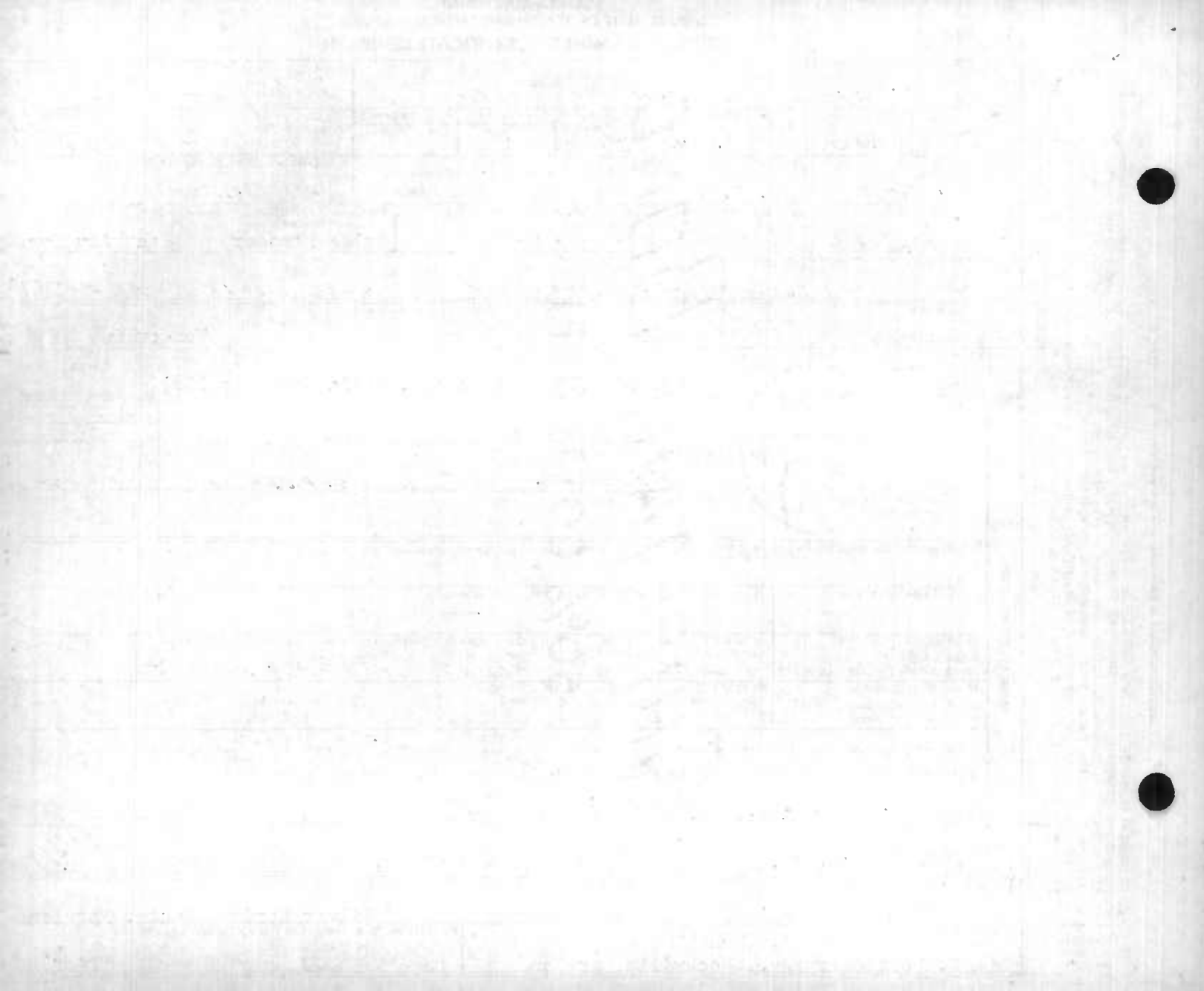
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FEB 28 1985

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- STATE REGISTRAR											
1. DECEASED NAME FIRST MIDDLE LAST MICHAEL JOSEPH TULLO										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2 10 1985	
3. SEX M										2b. HOUR 10 54 M	
4. RACE CAUC										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 10 1985	
5. DATE OF BIRTH MONTH DAY YEAR 7 30 45										2d. HOUR 10 54 M	
6. AGE (IN YEARS) LAST BIRTHDAY 39 YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York										7b. CITIZEN OF WHAT COUNTRY? U. S. A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH GAITHERSBURG										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16620 SIOUX LANE	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Manager										12b. KIND OF BUSINESS OR INDUSTRY Security System	
13a. STATE MD										13b. COUNTY MONTGOMERY	
13c. CITY OR TOWN GAITHERSBURG										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 16620 SIOUX LANE										20878	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Tullo										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Wanderling	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no										16b. SOCIAL SECURITY NO. 053-36-4970	
17. INFORMANT Helene M. Tullo (same as 13e)										ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. (b) HANGING DUE TO DEPRESSION DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDEX	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7-10 am 2 10 1985	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) FOUND IN BASEMENT											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Francis C. Mayle TITLE (SPECIFY) DEPT MEDICAL EXAMINER										DATE SIGNED 2-10-85	
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE ADDRESS 8200 Wisconsin Ave Bethesda MD										20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 2-13-85	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven										23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montg. Maryland	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A										25a. DATE REC'D. BY REGISTRAR FEB 19 1985	
300 W. Montgomery Ave., Rockville, Maryland										25b. REGISTRAR'S SIGNATURE John Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLADYS BROOKE B. TUMBLESON		2a. DATE OF DEATH MONTH DAY YEAR FEB. 5, 1985		2b. HOUR 8:40 P.M.	
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JULY 22, 1889		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 95	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education
13a. STATE Md.		13b. CITY OR TOWN Sandy Spring	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 2707 Olney Sandy Spring Rd. 20860
14. FATHER'S NAME FIRST MIDDLE LAST Charles F. Brooke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cornelia - Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 578-44-8625		17 INFORMANT ADDRESS Charles B. Henderson 314 Mansion Dr. Alexandria, Va. 22302	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR INSUFFICIENCY - DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN. Yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DEMENTIA - ORGANIC BRAIN SYNDROME					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 11/10 84 to 2/5 85	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE OLNEY, MD 20832	
22a. I certify that (1) this hospital attended the deceased from 1/15 85 to 2/5 85 , that (2) we last saw the deceased alive on 1/15 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death.)					
22b. SIGNATURE Dr. Donald Lewis		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-6-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Donald Lewis		22e. ADDRESS OLNEY, MD 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE Feb. 7, 1985		23c. NAME OF CEMETERY OR CREMATORY Balt. Wash. Crem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P. George Md.		23e. DATE REC'D. BY REGISTRAR FEB 13 1985			
24 FUNERAL DIRECTOR FRANCIS H. BARBER		24b. ADDRESS LAYTONSVILLE, MD. 20879			
24c. REGISTRAR'S SIGNATURE John Davidson-Randall		24d. ADDRESS FEB 13 1985			

MEDICAL CERTIFICATION
Cleared with Medical Examiner

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



[Faint, mostly illegible text and markings on lined paper, possibly bleed-through from the reverse side. Some words like "FEB 13" and "1963" are visible at the bottom.]

25

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MDHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 05847	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry Hice Wakeland						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2/10/1985		2b. HOUR 2:00 AM			
3. SEX M	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 10 20 1922	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 62 YRS.	IF UNDER 1 YR. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 2/10p/85		2d. HOUR 2:07 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK) Chief Scientist, National Safety Transportation Board		12b. KIND OF BUSINESS SAFETY			
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN POTOMAC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9013 CHERBOURG DRIVE			
14. FATHER'S NAME FIRST MIDDLE LAST Ray Warren Wakeland		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Kells Hice		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII		16b. SOCIAL SECURITY NO. 303-20-3582		17. INFORMANT ADDRESS Mrs. Barbara P. Wakeland, Wife, Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (d), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) GASTROINTESTINAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 2-3 DAYS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 0610 PM 2 10 1985		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 0610 PM 2 10 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) COLLAPSED IN EMERGENCY ROOM							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home Hospital		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5600 Old Georgetown Rd Bethesda Mont MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Francis C. Mayle				TITLE (SPECIFY) MD		MEDICAL EXAMINER 20818		DATE SIGNED 2-10-85			
EXAMINER'S NAME (TYPE OR PRINT) Francis C Mayle		ADDRESS 8200 Wisconsin Ave Bethesda MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE February 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Myrtle Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Tampa Florida					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes PA				25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE Jelia Davidson-Randall					
7557 Wisconsin Avenue Bethesda, Maryland 20814											

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Clair A. Wallace</i>			2a. DATE KNOWN OF DEATH MONTH <i>Feb</i> DAY <i>24</i> YEAR <i>1984</i> HOUR <i>8:55</i> AM		
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH <i>May</i> DAY <i>17</i> YEAR <i>1927</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>57</i> YRS.	IF UNDER 1 YR. MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN. _____
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Olney</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Montgomery General Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Owner/Operator-Parking Facility</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Belt Spg.</i>	
14. FATHER'S NAME FIRST <i>William</i> MIDDLE _____ LAST <i>Brown</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Hattie</i> MIDDLE <i>Schoonever</i> LAST _____		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>	
16b. SOCIAL SECURITY NO. <i>198 28 4310</i>		17. INFORMANT <i>Bob Wallace (son)</i>		ADDRESS <i>same address as #13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture Cervical Vert. & Neurological</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>None</i>					
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>1000 2 24 84 C2V Accident</i>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>1000 2 24 84</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>C2V Accident</i>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Street</i>		21f. LOCATION STREET <i>Newthampton St</i> CITY OR TOWN <i>Belt Spg.</i> COUNTY <i>Montgomery</i> STATE <i>MD</i>	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <i>MD</i>		MEDICAL EXAMINER <i>John S. Rogers</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, MD</i>		ADDRESS		DATE SIGNED <i>Feb 24 1984</i>	
23a. DATE OF REMOVAL, REMOVAL (DATE) <i>Feb. 27, 1985</i>		23b. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cemetery</i>		23c. LOCATION CITY OR TOWN <i>Wilkes-Barre, Pa.</i> COUNTY _____ STATE _____	
24. FUNERAL DIRECTOR NAME <i>Ives-Pearson Funeral Homes</i>		25a. DATE REC'D BY REGISTRAR <i>FEB 28 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

POST COTTON FIBRE

CHILLYA 10000



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANCES E WALTER			2a. DATE OF DEATH MONTH 2 - DAY 1 - YEAR 85		2b. HOUR 12.5 P.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH 7 - DAY 5 - YEAR 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REGISTERED NURSE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST THOMAS MIDDLE LAST COLLINS			15. MOTHER'S MAIDEN NAME FIRST KATHRYN MIDDLE LAST SCARRY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 159-22-7444		17. INFORMANT ADDRESS SON 1323 S. 78TH AVENUE PATRICK ADLEY OMAHA, NEBRASKA 68124	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic Necrosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hours 30 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Lymphoma					
19a. DATE OF OPERATION 15 Sept 84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (a) this hospital attended the deceased from 15 Sept 84 to 1 Feb 85 , that (b) (live) last saw the deceased alive on 30 Jan 85 , and that (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)					
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bransinger		22b. ADDRESS 7525 Greenway Center Drive Greenbelt MD		22c. DATE SIGNED 1 Feb 85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/6/85	23c. NAME OF CEMETERY OR CREMATORY NORTH SIDE CATHOLIC		23d. LOCATION CITY OR TOWN PITTSBURGH COUNTY PENNSYLVANIA
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD.			25a. DATE REC'D. BY REGISTRAR FEB 7 1985 25b. REGISTRAR'S SIGNATURE <i>Carleton Randall</i>		

WOLLY WAX
COTTON FIBER



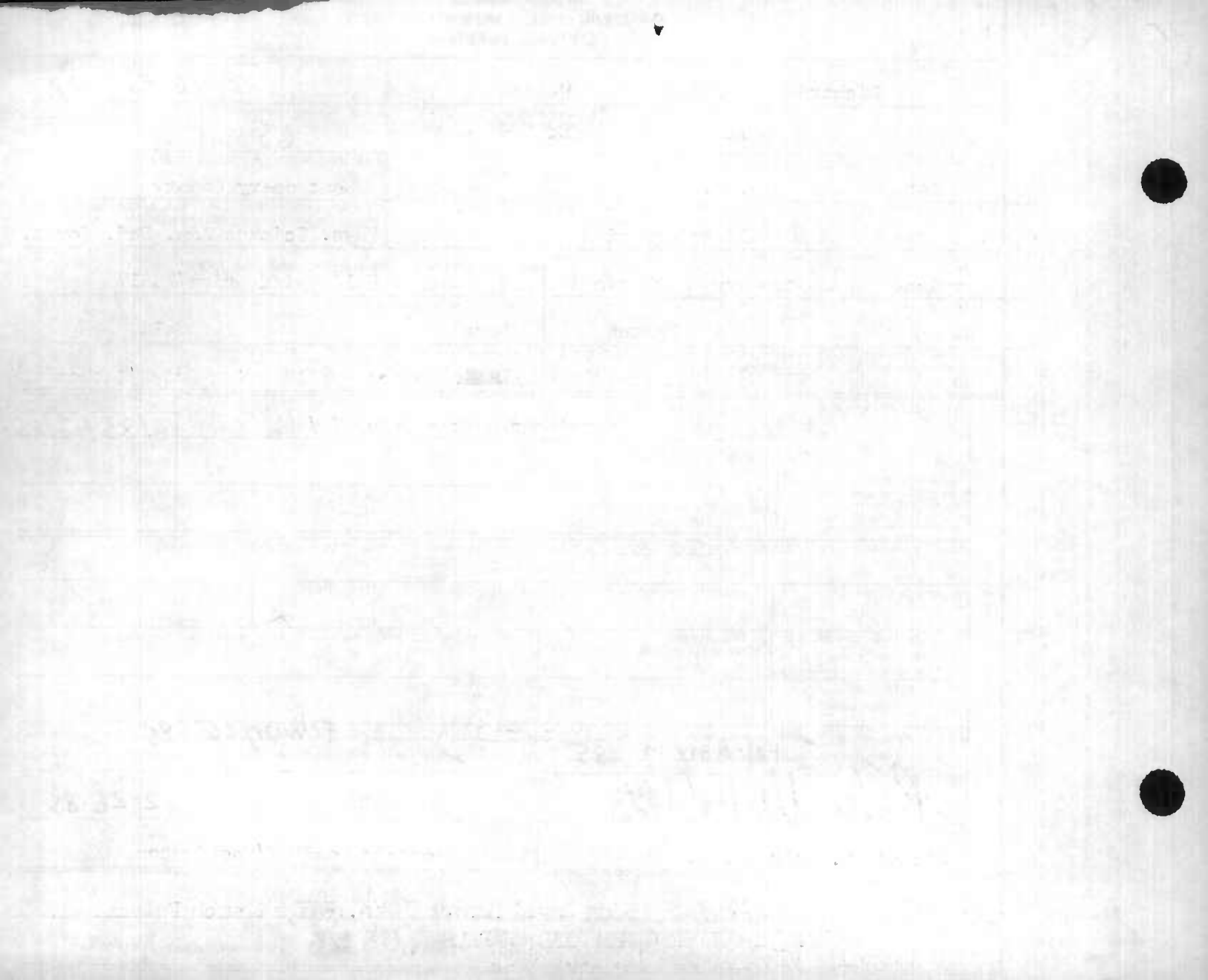
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard Selwyn Walton				2a. DATE OF DEATH MONTH DAY YEAR 2 26 85				2b. HOUR 8 A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 27, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8612 Ewing Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Phys. Science Adm.		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8612 Ewing Drive/20817	
14. FATHER'S NAME FIRST MIDDLE LAST Max Walton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Gold		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					
		16b. SOCIAL SECURITY NO. 222-12-4288		17. INFORMANT ADDRESS Lila B. Walton - 8612 Ewing Drive/Bethesda, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Colon (6/83) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6/83 to 2/85	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from February 14, 19 85, to February 26, 19 85, that I (we) last saw the deceased alive on February 20, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (ye) (did) (did not) view the body after death.									
22b. SIGNATURE Richard W. Holt				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-26-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard W. Holt, M. D.				22e. ADDRESS 3800 Reservoir Road NW/Washington, DC					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/28/85		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Gdn.; Falls Church; Fairfax; Va.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852									

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		Elsie			P.	Warburton	February 1, 1985			9:10 A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		6-16-02		82 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		United States				Montgomery County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Montgomery General Hospital						Homemaker		Own Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3642 Gleneagles Drive / 20906			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST	
George		H.		Pocock		Catherine				Willett	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		-		568-42-9907D		Mr. Donald L. Warburton, Son, 8510 Beaufort Drive, Fulton, MD. 20795					
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>									
		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia, & Necropsis</i>									
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Protein Caloric Deficiency</i>									
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Polymyalgia Rheumatica, Steroid treatment, Myocarditis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>1-28, 1985</i> to <i>2-1, 1985</i> , that (I) (we) lost saw the deceased alive on <i>1-31, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE						22c. DATE SIGNED			
<i>Oliver J. Lawless</i>		MD						<i>2-1-85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
OLIVER J. LAWLESS		Leisure World Medical Center.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		February 2, 1985		Metropolitan Crematory		Alexandria		Virginia			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey		Funeral Homes, P.A., Rockville, Maryland						<i>Feb 5 1985</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

05852

1. DECEASED-NAME (Type or print) WARD MAURICE CLARETT WARD			2a. DATE OF DEATH Month FEBRUARY Day 23 Year 85			2b. HOUR 7:30 A M.	
3. SEX male		4. RACE White		5. DATE OF BIRTH 7/3/20		6. AGE (In years lost birthday) 64 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH DARNESTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 14401 DARNESTOWN ROAD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SCHOOL ADMINISTRATOR		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN DARNESTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 14401 DARNESTOWN Rd. 20874		14. FATHER'S NAME First Middle Last MAURICE SPENCER WARD		15. MOTHER'S MAIDEN NAME First Middle Last MILDRED CLARETT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. 219-05-6520		17. INFORMANT BETTY T. WARD		Address 14401 DARNESTOWN Rd. DARNESTOWN Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the Pancreas DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus, Hypertension							
19a. DATE OF OPERATION Jan 24/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Biliary obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) _____			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) _____		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from January 19 85 , to 2/23, 1985 , that (I) (we) last saw the deceased alive on 2/21 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John J. Law				DEGREE MD		22c. DATE SIGNED 2/23/85	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/25/1985		23c. NAME OF CEMETERY OR CREMATORY DARNES TOWN PRESBYTERIAN CHURCH		23d. LOCATION (City or Town) (County) (State) DARNESTOWN MONTGOMERY Md.	
24. FUNERAL DIRECTOR W.C. HILTON				25a. REC'D BY REGISTRAR John Davidson-Randall		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

ADDRESS
**2211 BEALLSVILLE Rd.
BARNESVILLE, Md.**

DATE
FEB 27 1985

THE NATIONAL ARCHIVES
COLLECTION OF THE NATIONAL ARCHIVES
RECEIVED

RECEIVED
JAN 10 1967
U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked "yes," it shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
William		H.		W. b. b.				2-10-85		2:18 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		MONTH DAY YEAR Sept. 26 1896		88 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Tenn.		U.S.A.				Montgomery MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Gaithersburg		Herman H. Wilson Health Care Center								Lawyer		Legal	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Md.		Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		403 Russell Ave.		#616 (20877)			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Robert Henry Webb		Katharine Miller											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT									
Yes		WWI		577-03-2172		Estelle H. Webb		403 Russell Ave., #616		Gaithersburg, Md. 20877			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Bilateral Lower Lobe Pneumonia													
DUE TO, OR AS A CONSEQUENCE OF (b) Diabetic Melibros													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10 FEB 85 to 10 FEB 85, that (I) (we) last saw the deceased on 10 FEB 85, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE		22c. DATE SIGNED											
Thomas E. Dodley, MD		10 FEB 85											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Thomas E. Dodley, MD		1750 Y GORTON AVE											
		OZROY, MARYLAND 20832											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Cremation		2/11/85		Lee's Crematory		Washington, D.C.							
24a. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Gartner Sandison		316 E. Diamond Ave.		FEB 13 1985		John Sandison-Randall							
Gartner Sandison F.H.		Gaithersburg, Md. 20877											

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FOR 3/6/85 rja
1- STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 5 4

REG. NO.

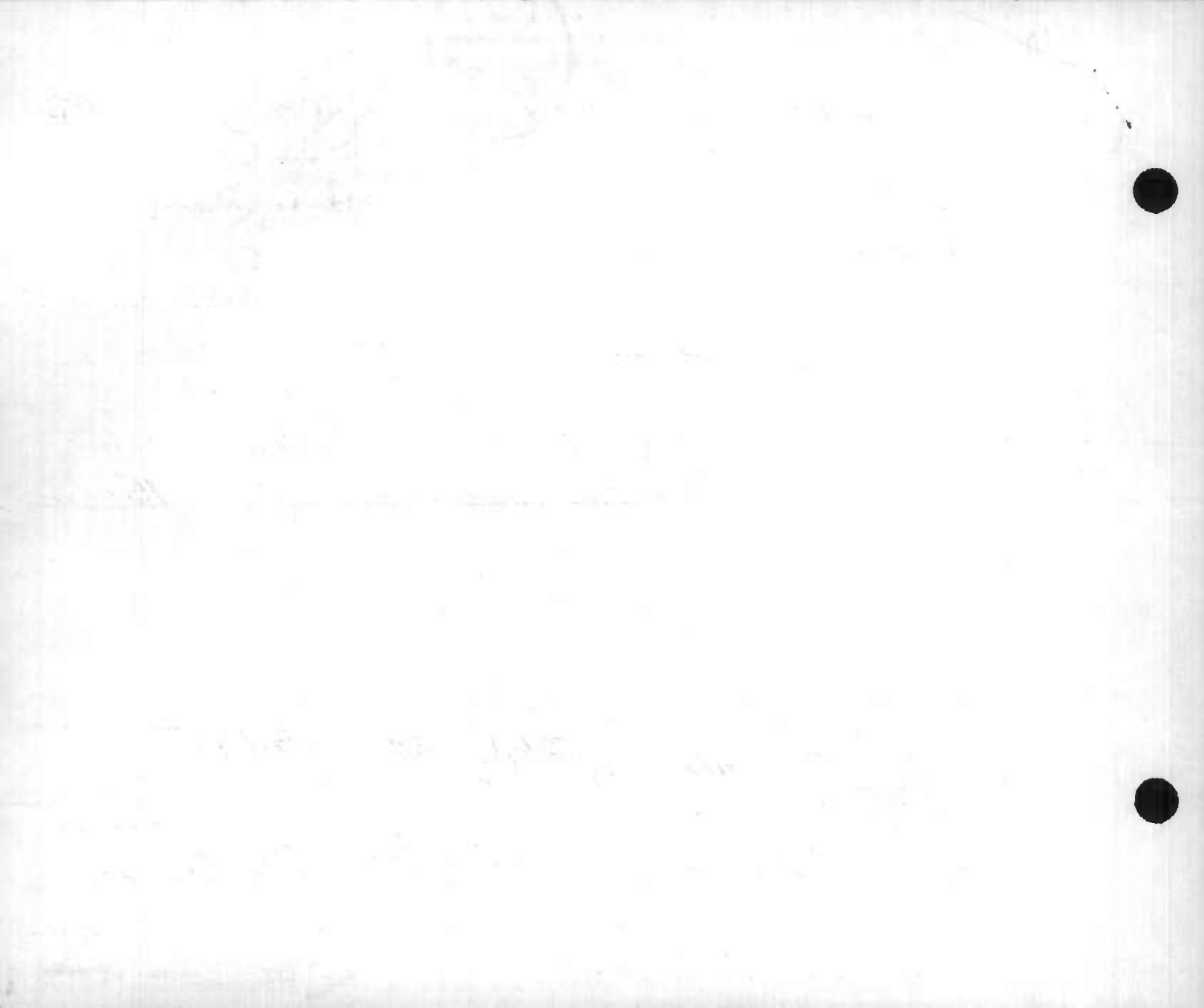
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANDREY S. Weber			2a. DATE OF DEATH MONTH DAY YEAR 2/21/85		2b. HOUR MIN. 12:25 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 11, 1921		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 63 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland				13b. CITY OR TOWN Rockville		13c. STREET ADDRESS / ZIP CODE 15317 Carrollton Rd. 20853	
14. FATHER'S NAME FIRST MIDDLE LAST Theodore Staeblein				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Diehl			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 205 16 5109		17. INFORMANT Husband ADDRESS Clifford Weber same as item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspirin pneumonia, bilateral DUE TO, OR AS A CONSEQUENCE OF (b) Multiple sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 15 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from July 1, 1980 to 2/21/85 , that (I) (we) last saw the deceased alive on 2/21 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Earl A. Raikow, MD				DEGREE MD		22c. DATE SIGNED 2/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 50 W. EDWARDS DRIVE ROCKVILLE, MD 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 25, 1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND				25a. DATE REC'D. BY REGISTRAR FEB 25 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Muriel nmn Wegner				2a. DATE OF DEATH MONTH DAY YEAR Feb. 10, 1985			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Practical Nurse		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Ray De Armond		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bess Shelley		16. SOCIAL SECURITY NO. 511-26-6443A			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 511-26-6443A		17. INFORMANT Rockville, Maryland 20850 Richard J. Wegner 617 Smallwood Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ESOPHAGEAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CIRRHOSIS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>1 YEAR</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>PNEUMONIA</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 31, 19 85</u> to <u>FEB 10, 19 85</u> , that (I) (we) last saw the deceased alive on <u>FEB 01, 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Alan Diamond</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan Diamond		22e. ADDRESS 1106 Spring Street, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/15/85		23c. NAME OF CEMETERY OR CREMATORY Norbeck Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Norbeck, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR FEB 20 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

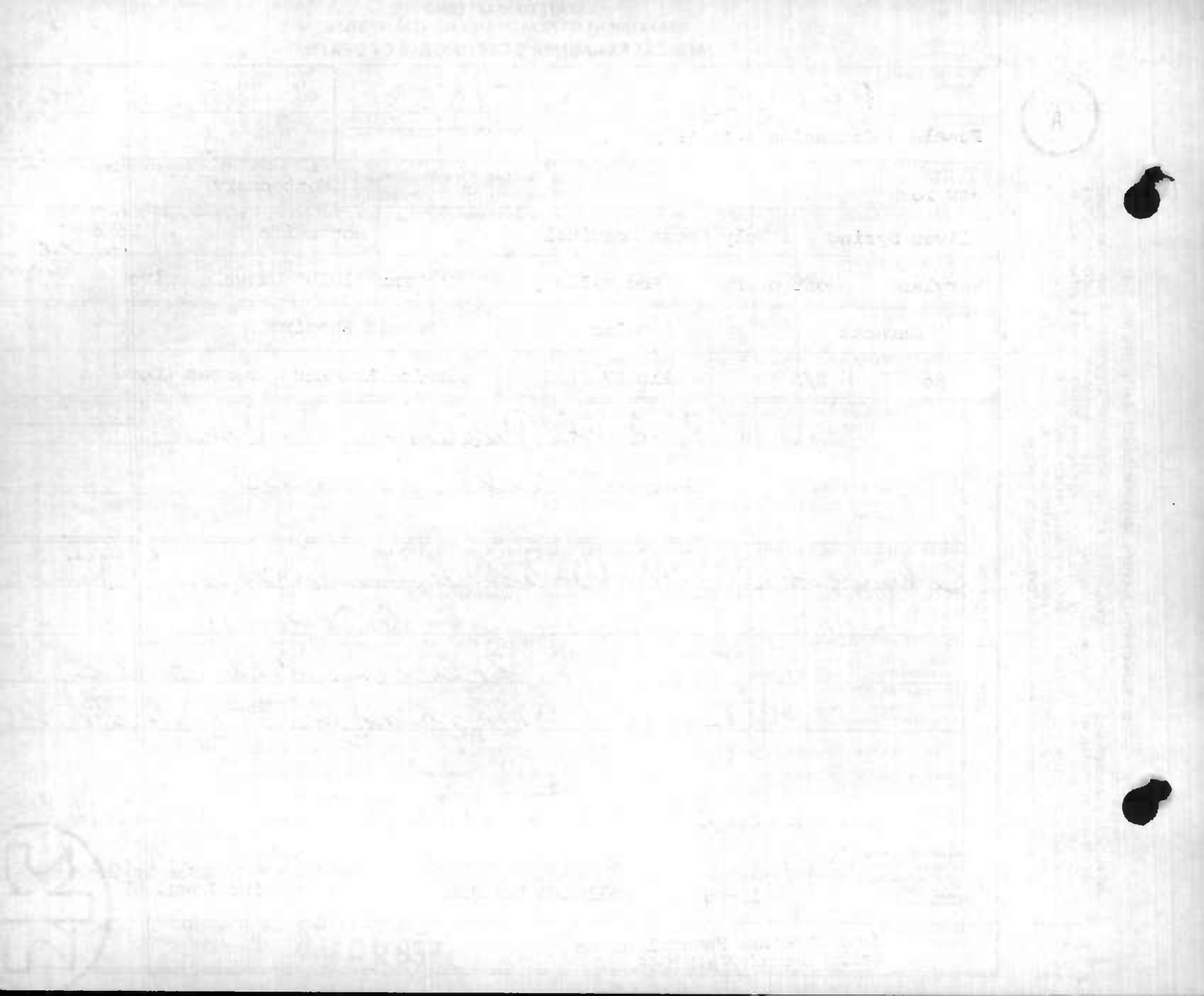
FOR
1- STATE
REGISTRAR

I. DECEASED NAME (TYPE OR PRINT) BELLE WEINER			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2-16-85			2b. HOUR 2:10 PM		
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 9-12-1888	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 96	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2-16-1985	2d. HOUR 2:10 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		
11. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIVING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13b. STREET ADDRESS 14100 Oakvale Drive		
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville						
14. FATHER'S NAME FIRST MIDDLE LAST Barnett Goler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Shapiro					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Bernice Brudner		ADDRESS same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Fractured left femur DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Advanced Atherosclerotic Cardiovascular Disease, Pulmonary								
19a. DATE OF OPERATION 2-11-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Traction pin for left femur		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2-9-85 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Fell from bed at home				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 14100 Oakvale St Rockville Md				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE Richard L. Whelton		TITLE (SPECIFY) Deputy			MEDICAL EXAMINER DATE SIGNED 2-16-85			
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON		ADDRESS 2100 Balt Ave College Park						
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 2-19-85		23c. NAME OF CEMETERY OR CREMATORY Wellwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pine Lawn MONTGOMERY MD		
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes				25a. DATE REC'D. BY REGISTRAR FEB 20 1985		25b. REGISTRAR'S SIGNATURE J. Davidson		
26. FALLS CHURCH, VA. 22046								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 05857

FOR
1- STATE
REGISTRAR

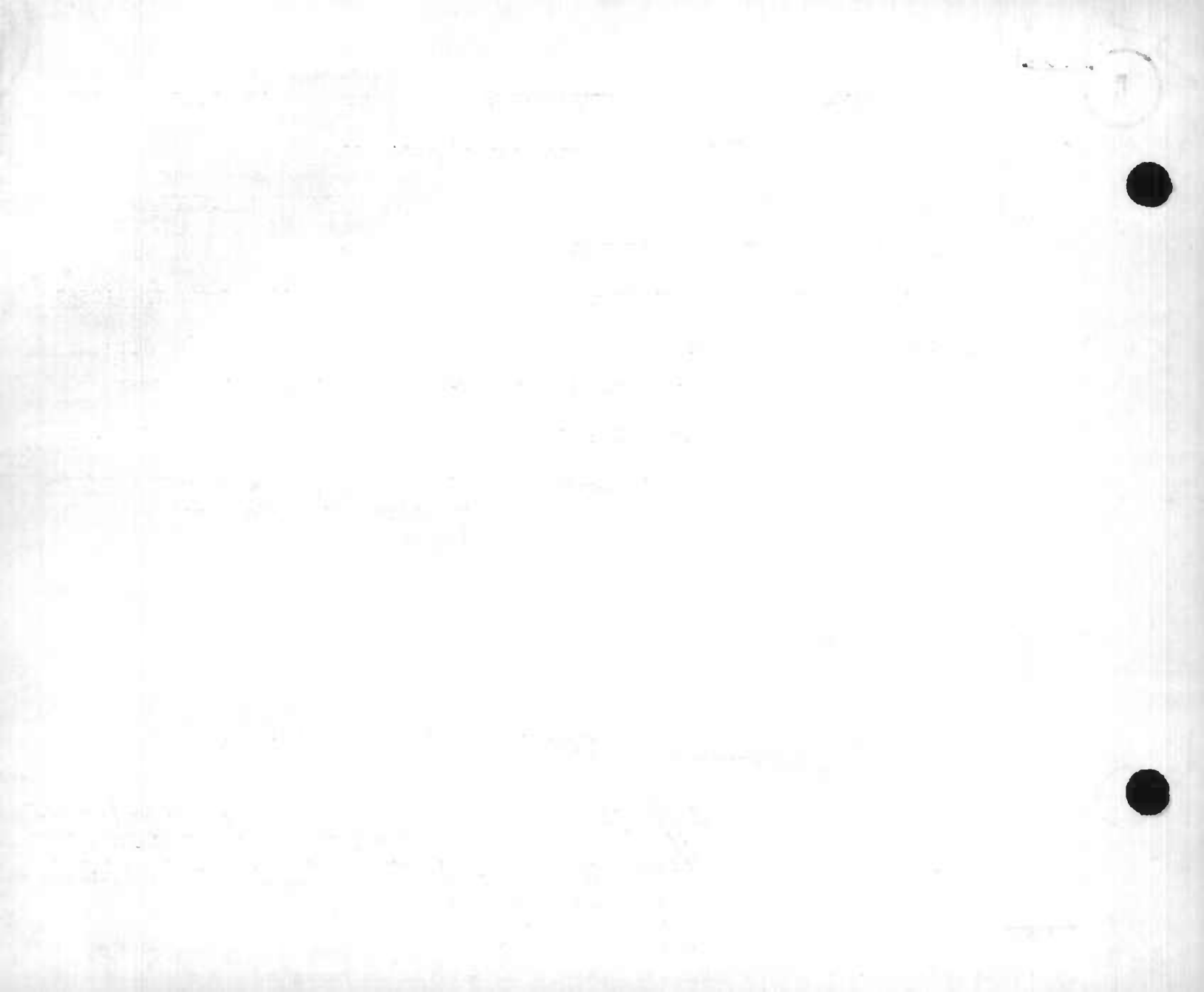
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYNOR NMI WEIZENECKER			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 19, 1985		2b. HOUR 1:45a M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 24, 1934		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. 50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheriff		12b. KIND OF BUSINESS OR INDUSTRY County	
13a. STATE NEW YORK		13b. COUNTY Putnam		13c. CITY OR TOWN PATTERSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE RR BOX 146, CROSS RD 12563		14. FATHER'S NAME FIRST MIDDLE LAST Christian Weizenecker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanne Jensen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea 130-30-9024		17. INFORMANT ADDRESS JOHN WEIZENECKER (BROTHER) SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Staphylococcal pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Alpha I Antitrypsin Deficiency Lung Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 18, 1979 to FEBRUARY 19, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEBRUARY 19, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>Anthony F. Suffredini</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/19/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY F. SUFFREDINI		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 23, 1985		23c. NAME OF CEMETERY OR CREMATORY Milltown Rural Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brewster, New York	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR FEB 25 1985		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 4 per phone 2/20/85 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 5 8

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Josephine CROGHAN WESTERN</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>2-2-85</i> 2b. HOUR <i>8 AM</i>	
3 SEX <i>F</i>	4 RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12 28 - 91</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>93</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VIRGINIA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Pro Health Care Center</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Nurse</i>	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) 13b. STATE <i>MD. Mont.</i>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS <i>3502 FARTHING DRIVE 20901</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>CROGHAN</i>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>	16b. SOCIAL SECURITY NO. <i>220-44-0034</i>	17. INFORMANT ADDRESS <i>JOHN J. WESTERN SAME AS 13 SON</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>May 27 1985</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>May 27 1985</i> to <i>Feb 2 1985</i> , that (1) (we) last saw the deceased alive on <i>May 27 1985</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Lewis Kellert, MD</i>	DEGREE <i>MD</i>	22c. DATE SIGNED <i>2/2/85</i>	22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lewis Kellert, MD</i>
22e. ADDRESS <i>4000 Olney Laytonsville Rd. Olney, MD. 20832</i>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>2/5/85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CEMETERY</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>SUITLAND PRI GEO MD.</i>
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 7 1985</i>	25b. REGISTRAR'S SIGNATURE <i>C. Davidson-Randall</i>
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIUS - WHITE			2a. DATE OF DEATH MONTH DAY YEAR FEB. 3, 1985		2b. HOUR 7:06 AM	
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 23 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist		12b. KIND OF BUSINESS OR INDUSTRY National Cancer Inst.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Mont.	13c. CITY OR TOWN Damascus	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Morris - White		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena - UNK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF NOT KNOWN, GIVE YEAR OR DATES) WWII 216-44-6740		17. INFORMANT ADDRESS 24728 Ridge Road Florence R. White Damascus, Md., 20872		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2/3 1/2						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____						
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/3</u> 19 <u>85</u> to <u>2/3</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>2/3</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Arthur Schoengold MD</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/3/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR SCHOENGOLD, M.D.		22e. ADDRESS 1811 Prince Philip Dr, Olney, Md 20832				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/4/85	23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
24. FUNERAL DIRECTOR <u>Gartner-Sandison</u> 316 E. Diamond Ave. F.H. Gaithersburg, Md. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 06 1985 <u>Julien Kriden-Rodriguez</u>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IDA MAE WILDING				2a. DATE OF DEATH MONTH DAY YEAR 2 8 85		2b. HOUR 5⁴⁰ pm M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 10 1898		6 AGE (IN YEARS LAST BIRTHDAY) YRS 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WILSON HEALTH CARE CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST Fielding D. Carpenter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah A. Warren			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-01-3631		17. INFORMANT ADDRESS Brother William V. Carpenter 2206 Darrow Street Silver Spring, Md. 20902			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma, Liver DUE TO, OR AS A CONSEQUENCE OF (c) 2 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased on 2/8/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN Thos G. Ward		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 2/9/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 11, 1985		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Maryland	
24. FUNERAL DIRECTOR NAME Francis J. Collins		24b. ADDRESS 500 University Blvd., W. Silver Spring, Md.		25a. DATE RECEIVED BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

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WALL

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WALL



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1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST LAST		MIDDLE		LAST		2. DATE OF DEATH		DAY YEAR		2b. HOUR	
Martina Williams								Feb. 2., 1985				9:10pM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Female		Black		MONTH DAY YEAR 12 9 96		88 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md. A. UEN		USA				Montgomery						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Olney		Montgomery General Hospital		Domestic									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS		20868	
Md		Montgomery		Spencerville						16804 Brogden Rd.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Joseph Lynn		Mary CARTER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		579-26-5096		Martha Rheubottom -		18610 New Hamp. Ave.							
						Ashton, MD. 20862							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardio pulmonary arrest													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) malnutrition													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a)													
Alzheimer's disease, severe peripheral vascular disease													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
12/20/84 12/28/84 1/6/85		Peripheral Vascular disease, gangrene		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12/14/84 19 to 2/2/85 19, that (I) (we) last saw the deceased alive on 2/2/85 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
Arthur F. Woodward Jr		MD		2/3/85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
Arthur F Woodward Jr		Suite 326 18111 Prince Philip Dr Olney MD 20832											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION BY OR OWN							
Burial		2-8-85		Arlington Nat'l Cem.		Arlington VA							
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
George R. Snowden		246 N. WASH. ST. Rockville, Md. 20850		FEB 07 1985		John T. ...							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a 72-hour certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Luella L. Williamson.			2a. DATE OF DEATH MONTH DAY YEAR Feb. 23, 1985		2b. HOUR 9.00 PM	
3 SEX /Female.	4 RACE White.	5. DATE OF BIRTH MONTH DAY YEAR Dec. 26, 1896	6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York,	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD.			
10 CITY OR TOWN OF DEATH Silver Spring.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Legal Sec. Dept. Of Army.	12b. KIND OF BUSINESS OR INDUSTRY Retired.		
13a. STATE Maryland.		13b. COUNTY Montgomery.	13c. CITY OR TOWN Silver Spring.	13d. INSIDE CITY LIMITS? NO	13e. STREET ADDRESS / ZIP CODE 2101 Fairland Rd. Silver Sp Md. 20910	
14 FATHER'S NAME FIRST MIDDLE LAST Frank Purdy.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not. Known.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 578-32-4494	17 INFORMANT ADDRESS Center, Pa. David L. Purdy. Box 121 A. Marion				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper respiratory infection DUE TO, OR AS A CONSEQUENCE OF (b) Organic brain syndrome DUE TO, OR AS A CONSEQUENCE OF (c) 8 yrs					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/2 19 77 to 2/23 85 , that I (we) lost saw the deceased alive on 1/16 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE George S. Kenton		DEGREE MD		22c. DATE SIGNED 2/25/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE S. KENTON		22e. ADDRESS 10620 GEORGIA AVE, SILVER SPRING MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation.		23b. DATE FEB. 25-1985	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory.		23d. LOCATION CITY OR TOWN COUNTY STATE P. G. Md.	
23e. DATE REC'D. BY REGISTRAR Feb 28 1985		23f. NAME OF REGISTRAR John Davidson				

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B above only injury, or other traumatic event, the medical examiner must be notified at once.

File G601 item 6
FOR
1 - STATE REGISTRAR 2/21/85 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
FIRST MARY K. WILLS			MONTH 2 DAY 18 YEAR 85			12:29 AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR		
FEMALE	CAUC	MONTH January DAY 15 YEAR 1893	82 92 YRS			MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
Colorado	U.S.A.		Montgomery MD.					
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring	2015 Cascade Road		Homemaker					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b INSIDE CITY LIMITS?			13c STREET ADDRESS / ZIP CODE		
13a STATE MONTGOMERY 13b COUNTY Silver Spring			YES <input type="checkbox"/> NO <input type="checkbox"/>			2015 Cascade Road 20902		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST John Fidler			FIRST MIDDLE LAST Rosetta Smith					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS		
No			509-07-4423			Charlotte Johnson Daughter Same as 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute Myocardial Infarct								HOURS
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease								4 YRS.
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary atherosclerosis								4 YRS.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
Diabetes Mellitus								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR					
21d INJURY OCCURRED			21e PLACE OF INJURY		21f LOCATION			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			[AT HOME STREET FACTORY OFFICE, FARM, ETC.]		STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from May 1980 to Feb. 18 1985, that (I) (we) lost saw the deceased above on Jan. 27 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE					DEGREE		22c DATE SIGNED	
Albert H. Grollman, M.D.					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2/18/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS			
ALBERT H. GROLLMAN, M.D.					1106 Spring St. Silver Spring Md. 20910			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Burial			Feb. 23, 1985		Green Mountain Cemetery		Boulder Colorado	
24 FUNERAL DIRECTOR					25a DATE REC'D. BY REGISTRAR			
Francis J. Collins					FEB 26 1985			
500 University Blvd., W. Silver Spring, Md.					25b REGISTRAR'S SIGNATURE			
					John Davidson Anderson			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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Clear by Dr. John Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death.

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 6 4

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MICHAEL L WILSON			2a DATE OF DEATH MONTH DAY YEAR February 5, 1985		2b HOUR 9:41a.m.
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR October 31, 1948	6 AGE (IN YEARS LAST BIRTHDAY) 36 YRS	7 IF UNDER 1 YEAR MONTHS DAYS # UNDER 74 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COMPUTER TECHNICIAN	12b KIND OF BUSINESS OR INDUSTRY BUREAU	
13a STATE Maryland		13b CITY OR TOWN Silver Spring	13c STREET ADDRESS / ZIP CODE 1711 Mt. Pisgah Lane #31 20910		
14 FATHER'S NAME FIRST MIDDLE LAST CECIL WILSON		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY KNIGHT			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 225-70-2008	17 INFORMANT MD 18612 ADDRESS 20740 WALKERS CHOICE RD. CECIL WILSON GAITHERSBURG		

18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a diabetes mellitus, chronic renal failure			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from Dec 1989 to Feb 5, 1985, that (I) (we) last saw the deceased alive on Feb 1, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.			
22b SIGNATURE Charles Rosen	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 2/6/85
22d PHYSICIAN'S NAME (TYPE OR PRINT) Mark Rosen MD		22e ADDRESS Silver Spring, MD	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE FEB 8, 1985	23c NAME OF CEMETERY OR CREMATORY OAKLAND MEMORIAL GARDENS	23d LOCATION CITY OR TOWN COUNTY STATE GETTYSBURG ADAMS PA
24 FUNERAL DIRECTOR NAME Richard L. Lutz	25a DATE REC'D. BY REGISTRAR FEB 11 1985	25b REGISTRAR'S SIGNATURE John Davidson-Randall	

100% COTTON FIBER

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 6 5

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Winifred F. Wilson			2a. DATE OF DEATH MONTH DAY YEAR 2-11-85			2b. HOUR 6:30A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 19 1890		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5713 Cromwell Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5713 Cromwell Drive 20816	
14. FATHER'S NAME FIRST MIDDLE LAST John Fairchild			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Tunison			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 578-66-9032			17. INFORMANT ADDRESS Bethesda, Md.			17. INFORMANT ADDRESS Barbara W Kohlmeier, 5902 Madawaska Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) chronic congestive heart failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks.	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic atrial fibrillation								years	
DUE TO, OR AS A CONSEQUENCE OF (c) coronary artery disease								years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 1972 , to 2-11 , 19 85 , that (I) (we) last saw the deceased alive on 1/19 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) use any other death.									
22b. SIGNATURE Russell M. Tilley, Jr. MD						DEGREE MD		22c. DATE SIGNED 2-11-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Russell M. Tilley, Jr.						22e. ADDRESS 4701 Mass. Ave. NW Wash., DC 20016			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/14/1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland		
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.						25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Bond	
5130 Wisc Ave., N W. Wash., D.C.									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK L WIRDZEK					2a. DATE OF DEATH MONTH DAY YEAR 2/24/85			2b. HOUR 11:30 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 2, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONT MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Steel Company	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Pennsylvania Indiana Blairsville					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 101 Morewood Ave. 99999		
14. FATHER'S NAME FIRST MIDDLE LAST Adam Wirdzek					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rose Kovalovsky				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Jerome Wirdzek 5016 McCall St., Rock., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONITIS DUE TO, OR AS A CONSEQUENCE OF (b) Admission to hospital DUE TO, OR AS A CONSEQUENCE OF (c) Admission to hospital PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ulcers - left foot; right vent disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									
21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21c. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 2/22/85 to 2/24/85 , that (I) (we) last saw the deceased alive on 2/22/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE Sanford N. Richman, M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22c. DATE SIGNED 2/29/85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sanford N. Richman, M.D.									
22e. ADDRESS Rockville, Md.									
23a. BURIAL, CREMATION, REMOVAL Burial									
23b. DATE Feb. 28, 1985									
23c. NAME OF CEMETERY OR CREMATORY Sts. Simon and Jude Cemetery									
23d. LOCATION CITY OR TOWN COUNTY STATE Blairsville, Pa.									
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes									
24b. ADDRESS Arlington, Va. 22201									
25a. DATE REC'D. BY REGISTRAR MAR 01 1985									
25b. REGISTRAR'S SIGNATURE John Davidson-Randall									

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Pneumonia

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

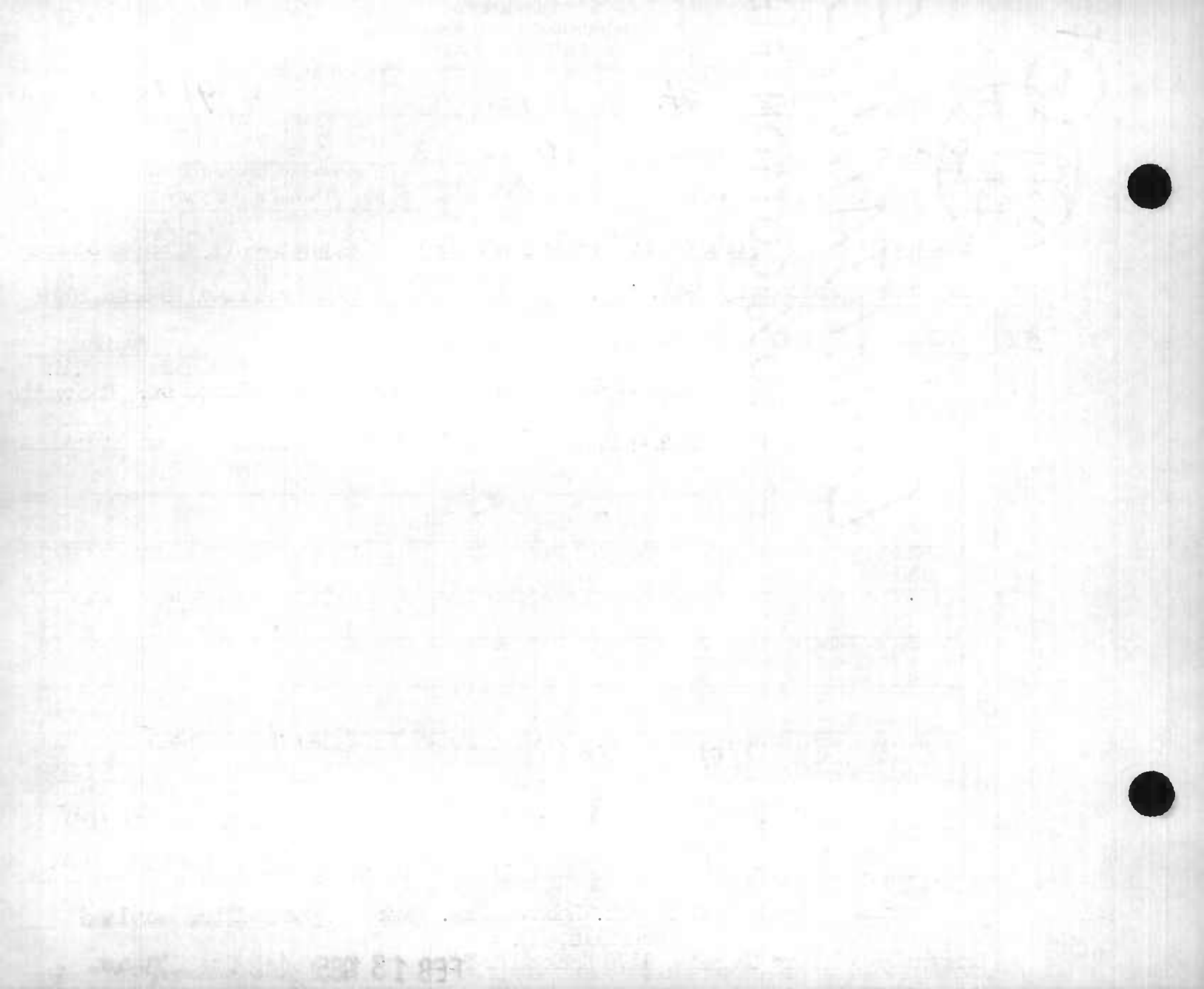
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NATHAN WORTH			2a. DATE OF DEATH MONTH 2 / DAY 9 / YEAR 85		2b. HOUR 5:58 ^M
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH 10 / DAY 16 / YEAR 98		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of G.W.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Shoe Store
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spg.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Chiam MIDDLE Worth LAST Worth			15. MOTHER'S MAIDEN NAME FIRST Shaindel MIDDLE Kraisal LAST Kraisal		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-09-0217		17. INFORMANT ADDRESS 20852 Md. Vera Mendelson; 6015 Neilwood Dr., Rockville	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kaposi's Sarcoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO, OR AS A CONSEQUENCE OF (c) —					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/16/84 to 2/9/85 , that (I) (we) lost saw the deceased alive on 2/9/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. D. Patel		DEGREE MD.		22c. DATE SIGNED 2/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. D. PATEL		22e. ADDRESS 6121 MONTROSE RD. ROCKVILLE MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-10-1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, Maryland		24. FUNERAL DIRECTOR NAME Rockville, Md. Danzansky-Goldberg Chapels; 1170 Rockville Pike			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE FEB 13 1985			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 6 8

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Josephine K. Vazbeck			2a. DATE OF DEATH MONTH DAY YEAR 2 13 85			2b. HOUR 10 ³⁷ PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 3 11		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) EGYPT		9. CITIZEN OF WHAT COUNTRY? PERMANENT RESIDENT USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
12. CITY OR TOWN OF DEATH Takoma Park		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		15. KIND OF BUSINESS OR INDUSTRY Housewife	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland		16b. CITY OR TOWN White Plains		16c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16d. STREET ADDRESS / ZIP CODE RT 1 Box 292 20695			
17. FATHER'S NAME FIRST MIDDLE LAST NATHAN K. HOUY		18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NOZHA P. KOURY		19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
20. 219-82-8080		21. INFORMANT 3807 OWEN CT. WALDORF, Md. (DAUGHTER) T. S. E. ROBERTSON							
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest with pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (b) advanced end stage atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) heart disease with congestive heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) Diabetes mellitus, insulin dependent, poorly controlled									
23a. DATE OF OPERATION		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED				23c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		23d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
25a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		25c. LOCATION STREET CITY OR TOWN COUNTY STATE					
26. I certify that (I) this hospital attended the deceased from 2-9-85 to 2-13-85, that (I) (was) lost saw the deceased alive on 2-13-85, and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
27a. SIGNATURE F. W. BRENNWALD		27b. DEGREE MD		27c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				27d. DATE SIGNED 2-14-85	
28a. PHYSICIAN'S NAME (TYPE OR PRINT) F. W. BRENNWALD		28b. ADDRESS 831 University Blvd E, Blue Spring							
29a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		29b. DATE FEB 16, 1985		29c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		29d. LOCATION CITY OR TOWN COUNTY STATE Arlington VA.			
30. FUNERAL DIRECTOR NAME DEVOI FUNERAL HOME		30b. ADDRESS WASH. D.C.		30c. DATE REC'D. BY REGISTRAR FEB 20 1985		30d. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in file 72 No. 1 of the file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is not marked, the medical examiner must be notified at once.

Y-0-17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.

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(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 8 6 9

1. FOR STATE REGISTRAR			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANN R YOUNGENTOB			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 6 1985 2-6-85		2b. HOUR 12 ³⁰ P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH JANUARY 19, 1901	6. AGE (IN YEARS LAST BIRTHDAY) 84	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON		12a. USUAL OCCUPATION (TYPE OF BUSINESS, OCCUPATION, OR WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BETHESDA	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL ROSENBERG			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIE CABLE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO 012-03-8039	17. INFORMANT ADDRESS PHILIP R. YOUNGENTOB, 4932 SENTINEL DRIVE BETHESDA, MARYLAND		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Viral Respiratory Infection</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Dementia (severe), Chronic Hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/1/84</u> to <u>2/6/85</u> , that (II) (we) last saw the deceased alive on <u>2/6/85</u> , and that in (my) (our) opinion death occurred on the date and hour from the causes stated above. (II) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stanley Cutler, MD</u>		DEGREE		22c. DATE SIGNED <u>2/6/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY CUTLER		22e. ADDRESS 6121 MONTROSE ROAD ROCKVILLE, MARYLAND 20852			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 2/10/1985		23c. NAME OF CEMETERY OR CREMATORY SHARE TEFILA CEMETERY	
				23d. LOCATION WEST ROXBURY, MASSACHUSETTS	
24. FUNERAL HOME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.			25a. DATE REC'D. BY REGISTRAR FEB 11 1985		
			25b. REGISTRAR'S SIGNATURE <u>John Davidson-Rodriguez</u>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

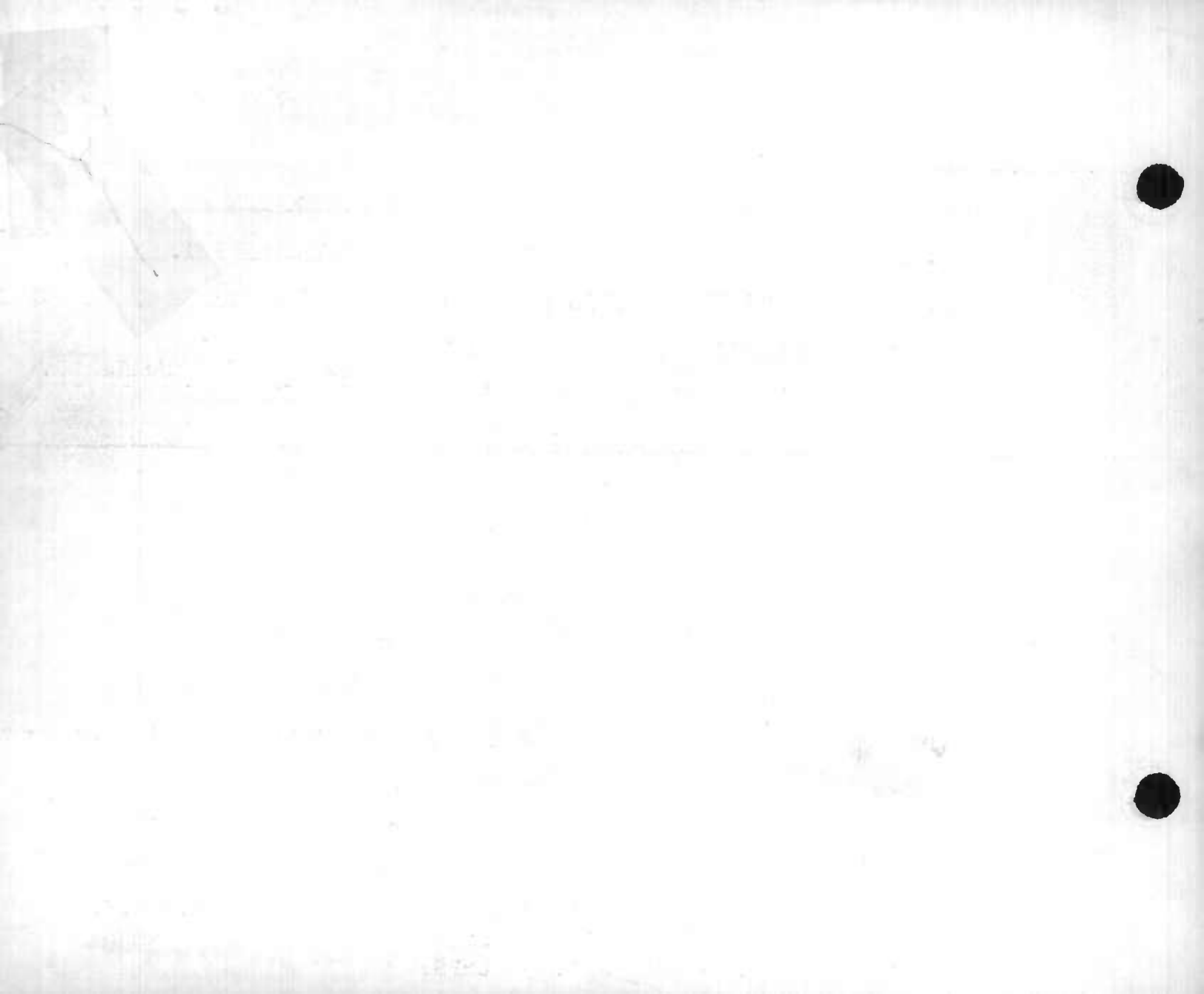
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Helmut. Karl Zacharias			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 2/25 19 85			2b. HOUR 8:20 A. M.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1932	6. AGE (IN YEARS) LAST BIRTHDAY 53 YRS.	IF UNDER 1 YR. MONTHS DAYS 53	IF UNDER 24 HRS. HOURS MIN. 53	2c. DATE PRONOUNCED DEAD 2/25 19 85			2d. HOUR 8:20 A. M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? Germany		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9 Marigold Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurateur		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9 Marigold Court 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Karl Zacharias			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henni Winnemuth						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-36-4580		17. INFORMANT Wife		ADDRESS Brigitte W. Zacharias Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute and chronic alcoholism. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None									
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>John S. Rogers</i>			M.D. Deputy			MEDICAL EXAMINER 1919 Seminary Road			DATE SIGNED 2/25/85
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			ADDRESS Silver Spring, Montgomery, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 1, 1985		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins				25. DATE REC'D. BY REGISTRAR MAR 1 1985		REGISTRAR'S SIGNATURE <i>John Davidson</i>			
500 University Blvd., W. Silver Spring, Md.									

: 3



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Hermine Zimmer		2a. DATE OF DEATH MONTH DAY YEAR 2-19-85		2b. HOUR 6:45 pm
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 05/25/01		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. May 25, 1901
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria	7b. CITIZEN OF WHAT COUNTRY? Montgomery	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Claims Adjustor	
12b. KIND OF BUSINESS OR INDUSTRY Aristo Dry Cleaners				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE 6121 Montrose Road (20852)				
14. FATHER'S NAME FIRST MIDDLE LAST Marcus Leibel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Paula Gottlieb		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-16-2723		17. INFORMANT ADDRESS D.C. 20008
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Suspected Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerosis Cardiovascular Disease</u>				
19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19	21b. TIME OF INJURY HOUR A.M. / MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/19</u> 19 <u>85</u> , to <u>2/19</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive or above (I) (we) (did) (did not) knew the body after death.				
22b. SIGNATURE <u>Raymond Bass</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-20-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND BASS		22e. ADDRESS 3929 Ferrara Dr Wheaton Md 20906		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/21/85	23c. NAME OF CEMETERY OR CREMATORY Elesavetgrad Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS		25a. DATE REC'D. BY REGISTRAR FEB 22 1985		
1170 Rockville Pike; Rockville, Md. 20852		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez		

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Released by Medical Examiner to 101 Bass AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED OF THE UNITED STATES DEPARTMENT OF THE INTERIOR

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